

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: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/23/2018 11:18 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 5/23/2018 Time: 11:18 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVOCATE TRINITY HOSPITAL (14-0048) 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)

DIRECTOR OF REIMBURSEMENT
Title

Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	653,665	12,529	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	653,665	12,529	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: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 10:37 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60617- County: COOK				
1.00 Street: 2320 E. 93RD ST.		2.00 City: CHICAGO								
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		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ADVOCATE TRINITY HOSPITAL	140048	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					01/01/2017	12/31/2017		20.00	
21.00	Type of Control (see instructions)					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.	1,380	1,810	0	0	6,463	281		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 10:37 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y	N			40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0048

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

Worksheet S-2
Part I
Date/Time Prepared:
5/23/2018 10:37 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00		
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
				1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010									
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00		
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
		1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00		
						1.00	2.00	3.00	
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			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)							0	71.00
Inpatient Rehabilitation Facility PPS									
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.					N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)							0	76.00

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.06	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					N		106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.					N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					N	N	N	N
						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: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 10:37 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	466,896	165,061	149,118		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		148036		140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 10:37 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	03/09/2018		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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					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.				Y		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	03/27/2018		Y	03/27/2018	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: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 10:37 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			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.			Y	40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SCOTT		MI TCHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTH CARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5761		SCOTT.MI TCHELL@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 10:37 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SR. REIMBURSEMENT SPECIALIST		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: 14-0048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 10:37 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	179	65,335	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)		179	65,335	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		203	74,095	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	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
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		203				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: 14-0048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 10:37 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,548	1,834	22,302			1.00
2.00 HMO and other (see instructions)	7,110	6,463				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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,548	1,834	22,302			7.00
8.00 INTENSIVE CARE UNIT	1,957	508	6,354			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		683	1,846			13.00
14.00 Total (see instructions)	8,505	3,025	30,502	0.00	793.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	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	92			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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	793.00	27.00
28.00 Observation Bed Days		290	6,001			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	446	532			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: 14-0048

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 10:37 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,979	819	7,532	1.00
2.00 HMO and other (see instructions)				1,661	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		1,979	819	7,532	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	0	0	17.00
18.00 SUBPROVIDER	0.00	0			0	0	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
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						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: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet S-3 Part II Date/Time Prepared: 5/23/2018 10:37 am	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	54,129,065	0	54,129,065	1,648,962.00	32.83	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		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		40,391	0	40,391	1,206.00	33.49	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		17,373	0	17,373	105.00	165.46	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		1,208,139	0	1,208,139	11,435.00	105.65	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		5,589,936	0	5,589,936	82,179.00	68.02	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		13,971,162	0	13,971,162			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,887	0	2,887			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		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		978,587	0	978,587			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,194,701	-903,901	290,800	4,410.00	65.94	26.00
27.00	Administrative & General	5.00	6,249,617	441,734	6,691,351	110,219.00	60.71	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0048

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

Worksheet S-3
Part II
Date/Time Prepared:
5/23/2018 10:37 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		1,037,019	0	1,037,019	4,988.00	207.90	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,268,619	40,257	2,308,876	80,704.00	28.61	30.00
31.00	Laundry & Linen Service	8.00	4,637	0	4,637	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,266,064	12,403	1,278,467	85,155.00	15.01	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,209,452	-436,029	773,423	46,342.00	16.69	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	447,497	447,497	27,206.00	16.45	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,180,803	52,564	2,233,367	51,522.00	43.35	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	2,627,737	7,542	2,635,279	49,088.00	53.68	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0048

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

Worksheet S-3
Part III
Date/Time Prepared:
5/23/2018 10:37 am

	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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	55,166,084	0	55,166,084	1,653,950.00	33.35	1.00
2.00	Excluded area salaries (see instructions)	40,391	0	40,391	1,206.00	33.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	55,125,693	0	55,125,693	1,652,744.00	33.35	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,815,448	0	6,815,448	93,719.00	72.72	4.00
5.00	Subtotal wage-related costs (see inst.)	14,949,749	0	14,949,749	0.00	27.12	5.00
6.00	Total (sum of lines 3 thru 5)	76,890,890	0	76,890,890	1,746,463.00	44.03	6.00
7.00	Total overhead cost (see instructions)	18,038,649	-337,933	17,700,716	459,634.00	38.51	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2018 10:37 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		972,017	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		1,038,109	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		4,584,439	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		1,346,758	9.00
10.00	Dental, Hearing and Vision Plan		175,246	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		59,419	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		418,218	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		744,100	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		3,770,657	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		235,160	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		242,074	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		387,852	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		13,974,049	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/23/2018 10:37 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		17,373	13,974,049 1.00
2.00	Hospital		17,373	13,974,049 2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC		0	0 14.00
15.00	Hospital-Based Health Clinic FQHC		0	0 15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10		0	0 16.10
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/23/2018 10:37 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.265919	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		37,208,875	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		151,413,883	6.00
7.00	Medicaid cost (line 1 times line 6)		40,263,828	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)		3,054,953	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		3,054,953	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,671,317	378,639	7,049,956
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,774,030	378,639	2,152,669
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	1,774,030	378,639	2,152,669
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		15,020,523	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,096,305	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,686,622	27.01
28.00	Non-Medicare bad debt expense (see instructions)		13,333,901	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,136,055	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,288,724	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		9,343,677	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0048

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

Worksheet A
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	0	5,983,049	5,983,049	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	0	3,190,924	3,190,924	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,194,701	9,960,788	11,155,489	-903,989	10,251,500
5.00	00500	ADMINISTRATIVE & GENERAL	6,249,617	40,214,854	46,464,471	-5,709,841	40,754,630
7.00	00700	OPERATION OF PLANT	2,268,619	6,087,082	8,355,701	10,822	8,366,523
8.00	00800	LAUNDRY & LINEN SERVICE	4,637	546,276	550,913	0	550,913
9.00	00900	HOUSEKEEPING	1,266,064	814,991	2,081,055	1,380	2,082,435
10.00	01000	DIETARY	1,209,452	1,643,519	2,852,971	-1,093,907	1,759,064
11.00	01100	CAFETERIA	0	0	0	1,055,599	1,055,599
13.00	01300	NURSING ADMINISTRATION	2,180,803	391,961	2,572,764	16,611	2,589,375
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	2,627,737	6,535,059	9,162,796	-5,550,344	3,612,452
16.00	01600	MEDICAL RECORDS & LIBRARY	0	50,503	50,503	-2,587	47,916
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,837,214	6,389,200	21,226,414	-1,548,249	19,678,165
31.00	03100	INTENSIVE CARE UNIT	4,033,481	1,841,469	5,874,950	-954,057	4,920,893
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	752,140	138,374	890,514	-65,680	824,834
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,599,392	6,173,421	9,772,813	-4,990,035	4,782,778
51.00	05100	RECOVERY ROOM	463,144	92,281	555,425	-52,534	502,891
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	23,585	1,862,610	1,886,195	-210,984	1,675,211
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,182,269	3,024,132	7,206,401	-1,649,463	5,556,938
56.00	05600	RADIOISOTOPE	261,231	499,020	760,251	-450,487	309,764
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	8,989	1,821,309	1,830,298	-1,855,917	-25,619
60.00	06000	LABORATORY	0	6,016,675	6,016,675	-419,729	5,596,946
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,183,066	380,175	1,563,241	-264,218	1,299,023
66.00	06600	PHYSICAL THERAPY	1,079,044	167,071	1,246,115	-5,680	1,240,435
67.00	06700	OCCUPATIONAL THERAPY	275,552	23,255	298,807	-216	298,591
68.00	06800	SPEECH PATHOLOGY	100,927	9,440	110,367	-1,108	109,259
69.00	06900	ELECTROCARDIOLOGY	663,691	159,952	823,643	-53,927	769,716
70.00	07000	ELECTROENCEPHALOGRAPHY	46,595	9,504	56,099	-5,024	51,075
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,671,258	7,671,258
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	3,099,594	3,099,594
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,215,005	6,215,005
74.00	07400	RENAL DIALYSIS	608,130	279,431	887,561	-145,355	742,206
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	183,371	30,574	213,945	-12,584	201,361
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	500,239	367,205	867,444	-71,830	795,614
91.00	09100	EMERGENCY	4,284,984	6,062,159	10,347,143	-1,223,923	9,123,220
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,088,674	101,592,290	155,680,964	2,574	155,683,538
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	NONREIMPARAMED RT	0	0	0	0	0
194.00	07951	NONREIMBURSABLE COST CENTERS	40,391	103,033	143,424	-2,574	140,850
200.00		TOTAL (SUM OF LINES 118 through 199)	54,129,065	101,695,323	155,824,388	0	155,824,388

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0048

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

Worksheet A
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	220,594	6,203,643	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	826,945	4,017,869	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,417,384	12,668,884	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-20,086,497	20,668,133	5.00
7.00	00700	OPERATION OF PLANT	-63,461	8,303,062	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	550,913	8.00
9.00	00900	HOUSEKEEPING	-89	2,082,346	9.00
10.00	01000	DIETARY	-4,065	1,754,999	10.00
11.00	01100	CAFETERIA	-483,292	572,307	11.00
13.00	01300	NURSING ADMINISTRATION	-34	2,589,341	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	-540	3,611,912	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,179	44,737	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,875,492	17,802,673	30.00
31.00	03100	INTENSIVE CARE UNIT	-81	4,920,812	31.00
32.00	03200	CORONARY CARE UNIT	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	824,834	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	4,782,778	50.00
51.00	05100	RECOVERY ROOM	-33	502,858	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-1,617,049	58,162	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-565,266	4,991,672	54.00
56.00	05600	RADIOISOTOPE	0	309,764	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	-25,619	59.00
60.00	06000	LABORATORY	-174,825	5,422,121	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	-915	1,298,108	65.00
66.00	06600	PHYSICAL THERAPY	-34,881	1,205,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	298,591	67.00
68.00	06800	SPEECH PATHOLOGY	0	109,259	68.00
69.00	06900	ELECTROCARDIOLOGY	0	769,716	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	51,075	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,671,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,099,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,215,005	73.00
74.00	07400	RENAL DIALYSIS	0	742,206	74.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	201,361	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	795,614	90.00
91.00	09100	EMERGENCY	-2,261	9,120,959	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-21,447,037	134,236,501	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	NONREIMPARAMED RT	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	-10,496	130,354	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,457,533	134,366,855	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
B - COST OF DRUGS 9929					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,215,005	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
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
TOTALS			0	6,215,005	
C - MEDICAL SUPPLIES 9929					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,770,852	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
TOTALS			0	10,770,852	
D - DERPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	5,983,049	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	3,190,924	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
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

RECLASSIFICATIONS

Provider CCN: 14-0048

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
	TOTALS		0	9,173,973	
E - RECLASS CAFETERIA					
1.00	CAFETERIA	11.00	447,497	608,102	1.00
	TOTALS		447,497	608,102	
F - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	3,099,594	1.00
	TOTALS		0	3,099,594	
G - INCENTIVE COMP					
1.00	ADMINISTRATIVE & GENERAL	5.00	426,534	0	1.00
2.00	OPERATION OF PLANT	7.00	27,427	0	2.00
5.00	NURSING ADMINISTRATION	13.00	45,410	0	5.00
7.00	ADULTS & PEDIATRICS	30.00	89,232	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	8,803	0	8.00
10.00	OPERATING ROOM	50.00	8,803	0	10.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	30,556	0	13.00
15.00	RESPIRATORY THERAPY	65.00	6,650	0	15.00
16.00	PHYSICAL THERAPY	66.00	10,006	0	16.00
17.00	CLINIC	90.00	4,300	0	17.00
	TOTALS		657,721	0	
H - ASSOCIATE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	15,200	0	1.00
2.00	OPERATION OF PLANT	7.00	12,830	0	2.00
3.00	HOUSEKEEPING	9.00	12,403	0	3.00
4.00	DIETARY	10.00	11,468	0	4.00
5.00	NURSING ADMINISTRATION	13.00	7,154	0	5.00
6.00	PHARMACY	15.00	7,542	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	84,888	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	15,976	0	8.00
9.00	NURSERY	43.00	3,187	0	9.00
10.00	OPERATING ROOM	50.00	15,434	0	10.00
11.00	RECOVERY ROOM	51.00	1,672	0	11.00
12.00	ANESTHESIOLOGY	53.00	350	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	19,398	0	13.00
14.00	RADIOISOTOPE	56.00	700	0	14.00
15.00	RESPIRATORY THERAPY	65.00	5,365	0	15.00
16.00	PHYSICAL THERAPY	66.00	3,849	0	16.00
17.00	OCCUPATIONAL THERAPY	67.00	1,205	0	17.00
18.00	SPEECH PATHOLOGY	68.00	350	0	18.00
19.00	ELECTROCARDIOLOGY	69.00	2,293	0	19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	505	0	20.00
21.00	RENAL DIALYSIS	74.00	1,905	0	21.00
22.00	CARDIAC REHABILITATION	76.97	894	0	22.00
23.00	CLINIC	90.00	1,516	0	23.00
24.00	EMERGENCY	91.00	20,096	0	24.00
	TOTALS		246,180	0	
500.00	Grand Total: Increases		1,351,398	29,867,526	500.00

RECLASSIFICATIONS

Provider CCN: 14-0048

Period:
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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 - COST OF DRUGS 9929						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	40,209	0	1.00
2.00	HOUSEKEEPING	9.00	0	1,835	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	920	0	3.00
4.00	PHARMACY	15.00	0	5,422,168	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	203,149	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	82,134	0	6.00
7.00	NURSERY	43.00	0	614	0	7.00
8.00	OPERATING ROOM	50.00	0	160,465	0	8.00
9.00	RECOVERY ROOM	51.00	0	5,420	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	7,962	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,950	0	11.00
12.00	RADIOISOTOPE	56.00	0	1,285	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	15,669	0	13.00
16.00	ELECTROCARDIOLOGY	69.00	0	2,396	0	16.00
17.00	RENAL DIALYSIS	74.00	0	5,416	0	17.00
18.00	CLINIC	90.00	0	6,728	0	18.00
19.00	EMERGENCY	91.00	0	249,685	0	19.00
TOTALS			0	6,215,005		
C - MEDICAL SUPPLIES 9929						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,809	0	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	88	0	2.00
3.00	OPERATION OF PLANT	7.00	0	11	0	3.00
4.00	HOUSEKEEPING	9.00	0	7,003	0	4.00
5.00	DIETARY	10.00	0	38	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	1,746	0	6.00
7.00	PHARMACY	15.00	0	56,191	0	7.00
8.00	NONREIMBURSABLE COST CENTERS	194.00	0	1,688	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	903,345	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	455,635	0	10.00
11.00	NURSERY	43.00	0	21,945	0	11.00
12.00	OPERATING ROOM	50.00	0	4,417,594	0	12.00
13.00	RECOVERY ROOM	51.00	0	18,359	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	73,265	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,283,516	0	15.00
16.00	RADIOISOTOPE	56.00	0	371,257	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	1,429,792	0	17.00
18.00	LABORATORY	60.00	0	408,184	0	18.00
19.00	RESPIRATORY THERAPY	65.00	0	230,730	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	11,329	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	1,421	0	21.00
22.00	SPEECH PATHOLOGY	68.00	0	1,458	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	11,868	0	23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,009	0	24.00
25.00	RENAL DIALYSIS	74.00	0	132,710	0	25.00
26.00	CARDIAC REHABILITATION	76.97	0	10,064	0	26.00
27.00	CLINIC	90.00	0	68,197	0	27.00
28.00	EMERGENCY	91.00	0	841,600	0	28.00
TOTALS			0	10,770,852		
D - DEPRECIATION EXPENSE						
1.00		0.00	0	0	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	6,102,557	9	2.00
3.00	OPERATION OF PLANT	7.00	0	29,424	0	3.00
4.00	HOUSEKEEPING	9.00	0	2,185	0	4.00
5.00	DIETARY	10.00	0	49,738	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	33,287	0	6.00
7.00	PHARMACY	15.00	0	79,527	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,587	0	8.00
10.00	ADULTS & PEDIATRICS	30.00	0	615,875	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	0	441,067	0	11.00
12.00	NURSERY	43.00	0	46,308	0	12.00
13.00	OPERATING ROOM	50.00	0	436,213	0	13.00
14.00	RECOVERY ROOM	51.00	0	30,427	0	14.00
15.00	ANESTHESIOLOGY	53.00	0	130,107	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	406,951	0	16.00
17.00	RADIOISOTOPE	56.00	0	78,645	0	17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	410,456	0	18.00
19.00	LABORATORY	60.00	0	11,545	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	45,503	0	20.00
21.00	PHYSICAL THERAPY	66.00	0	8,206	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	0	41,956	0	22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,520	0	23.00
24.00	RENAL DIALYSIS	74.00	0	9,134	0	24.00
25.00	CARDIAC REHABILITATION	76.97	0	3,414	0	25.00

RECLASSIFICATIONS

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Period:
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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
26.00	CLINIC	90.00	0	2,721	0		26.00
27.00	EMERGENCY	91.00	0	152,734	0		27.00
28.00	NONREIMBURSABLE COST CENTERS	194.00	0	886	0		28.00
	TOTALS		0	9,173,973			
E - RECLASS CAFETERIA							
1.00	DIETARY	10.00	447,497	608,102	0		1.00
	TOTALS		447,497	608,102			
F - IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,099,594	0		1.00
	TOTALS		0	3,099,594			
G - INCENTIVE COMP							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	657,721	0	0		1.00
2.00		0.00	0	0	0		2.00
5.00		0.00	0	0	0		5.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
10.00		0.00	0	0	0		10.00
13.00		0.00	0	0	0		13.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
	TOTALS		657,721	0			
H - ASSOCIATE BONUS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	246,180	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
	TOTALS		246,180	0			
500.00	Grand Total: Decreases		1,351,398	29,867,526			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0048

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		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,847,978	0	0	0	0	1.00
2.00	Land Improvements	4,518,954	0	0	0	0	2.00
3.00	Buildings and Fixtures	124,102,394	6,368,821	0	6,368,821	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	41,049,815	3,065,047	0	3,065,047	807,121	5.00
6.00	Movable Equipment	131,759	0	0	0	78,359	6.00
7.00	HIT designated Assets	619,543	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	174,270,443	9,433,868	0	9,433,868	885,480	8.00
9.00	Reconciling Items	-3,190,664	-4,743,787	0	-4,743,787	-269,961	9.00
10.00	Total (line 8 minus line 9)	177,461,107	14,177,655	0	14,177,655	1,155,441	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,847,978	0				1.00
2.00	Land Improvements	4,518,954	1,106,850				2.00
3.00	Buildings and Fixtures	130,471,215	27,721,637				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	43,307,741	21,961,915				5.00
6.00	Movable Equipment	53,400	53,400				6.00
7.00	HIT designated Assets	619,543	268,849				7.00
8.00	Subtotal (sum of lines 1-7)	182,818,831	51,112,651				8.00
9.00	Reconciling Items	-7,664,490	0				9.00
10.00	Total (line 8 minus line 9)	190,483,321	51,112,651				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0048

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0048

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Worksheet A-7
Part III
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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	NEW CAP REL COSTS-BLDG & FIXT	4	0	4	0.800000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1	0	1	0.200000	0	2.00
3.00	Total (sum of lines 1-2)	5	0	5	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	6,203,643	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	4,017,869	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	10,221,512	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	6,203,643	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,017,869	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	10,221,512	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0048

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

Worksheet A-8

Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW 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)		0		0.00		0	7.00
8.00 Television and radio service (chapter 21)		0		0.00		0	8.00
9.00 Parking lot (chapter 21)		0		0.00		0	9.00
10.00 Provider-based physician adjustment	A-8-2	-4,015,236				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-4,700,207				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-483,292	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts		0		0.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
20.00 Vending machines		0		0.00		0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00		0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00		0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY	65.00			23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00			24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00			25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		0	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		OCCUPATIONAL THERAPY	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			OADULTS & PEDIATRICS	30.00			30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY	68.00			31.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0048

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

Worksheet A-8

Date/Time Prepared:
5/23/2018 10:37 am

Line #	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.	Ref.	
				Cost Center	Line #			
				1.00	2.00			3.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00	NONALLOWABLE INTEREST EXPENSE	A	-1,777,856	ADMINISTRATIVE & GENERAL		5.00	0	33.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	37.00
38.00	MEDICAID ASSESSMENT FROM F/S	A	-8,648,107	ADMINISTRATIVE & GENERAL		5.00	0	38.00
40.00	PBP	A	-41,872	ADMINISTRATIVE & GENERAL		5.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	41.00
42.00	ADD MEDICARE DEPRECIATION	A	-87,647	NEW CAP REL COSTS-BLDG & FIXT		1.00	9	42.00
43.00	ADD MEDICARE DEPRECIATION	A	-2,448	NEW CAP REL COSTS-MVBLE EQUIP		2.00	9	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	44.00
45.00	LOBBYING COSTS	A	-32,717	ADMINISTRATIVE & GENERAL		5.00	0	45.00
45.05	PHO EXPENSE	A	-1,017,237	ADMINISTRATIVE & GENERAL		5.00	0	45.05
45.06	HOSPICE	A	-46,000	ADULTS & PEDIATRICS		30.00	0	45.06
45.07	MISC INCOME	B	-174,825	LABORATORY		60.00	0	45.07
45.08	MISC INCOME	B	-67,320	ADMINISTRATIVE & GENERAL		5.00	0	45.08
45.09	MISC INCOME	B	-798	ADULTS & PEDIATRICS		30.00	0	45.09
45.10	MISC INCOME	B	-63,411	OPERATION OF PLANT		7.00	0	45.10
45.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.11
45.12	MISC INCOME	B	-3,179	MEDICAL RECORDS & LIBRARY		16.00	0	45.12
45.13	MISC INCOME	B	-200	PHARMACY		15.00	0	45.13
45.14	MISC INCOME	B	-600	RESPIRATORY THERAPY		65.00	0	45.14
45.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.15
45.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.16
45.17	MISC INCOME	B	-9,930	PHYSICAL THERAPY		66.00	0	45.17
45.18	NON ALLOWABLE	A	-58,267	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	45.18
45.19	NON ALLOWABLE	A	-187,362	ADMINISTRATIVE & GENERAL		5.00	0	45.19
45.20	NON ALLOWABLE	A	-50	OPERATION OF PLANT		7.00	0	45.20
45.21	NON ALLOWABLE	A	-340	PHARMACY		15.00	0	45.21
45.22	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.22
45.23	NON ALLOWABLE	A	-89	HOUSEKEEPING		9.00	0	45.23
45.24	NON ALLOWABLE	A	-530	ANESTHESIOLOGY		53.00	0	45.24
45.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.25
45.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.26
45.27	NON ALLOWABLE	A	-707	EMERGENCY		91.00	0	45.27
45.28	NON ALLOWABLE	A	-34	NURSING ADMINISTRATION		13.00	0	45.28
45.29	NON ALLOWABLE	A	-4,065	DIETARY		10.00	0	45.29
45.30	NON ALLOWABLE	A	-10,496	NONREIMBURSABLE COST CENTERS		194.00	0	45.30
45.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.31
45.45	NON ALLOWABLE	A	-315	RESPIRATORY THERAPY		65.00	0	45.45
45.46	NON ALLOWABLE	A	-8,582	ADULTS & PEDIATRICS		30.00	0	45.46
45.47	NON ALLOWABLE	A	-726	PHYSICAL THERAPY		66.00	0	45.47
45.48	NON ALLOWABLE	A	-7,884	RADIOLOGY-DIAGNOSTIC		54.00	0	45.48
45.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.49
45.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.50
46.00	PATIENT TRANSPORT	A	-534	ADMINISTRATIVE & GENERAL		5.00	0	46.00
46.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	46.01
46.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	46.02
46.03	PATIENT TRANSPORT	A	-3,002	ADULTS & PEDIATRICS		30.00	0	46.03
46.04	PATIENT TRANSPORT	A	-81	INTENSIVE CARE UNIT		31.00	0	46.04
46.05	PATIENT TRANSPORT	A	-33	RECOVERY ROOM		51.00	0	46.05
46.06	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	46.06
46.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	46.07

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0048

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

Worksheet A-8

Date/Time Prepared:
5/23/2018 10:37 am

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		
46.08 PATIENT TRANSPORT	A	-1,554	EMERGENCY	91.00	0	46.08
46.09 OTHER ADJUSTMENTS (SPECIFY (3))		0		0.00	0	46.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,457,533				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: 14-0048

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

Worksheet A-8-1

Date/Time Prepared:
5/23/2018 10:37 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	PERSONNEL	2,475,651	0 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	DATA PROCESSING	2,335,030	0 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN & GENERAL	2,534,092	13,182,614 3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	DEPRECIATION	308,241	0 4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	DEPRECIATION	829,393	0 4.01
4.02	0.00			0	0 4.02
4.03	0.00			0	0 4.03
5.00	0	0	0	8,482,407	13,182,614 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.

Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	TRINITY HOSPITAL	100.00	ADVOCATE HEALTHCARE	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: 14-0048

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

Worksheet A-8-1

Date/Time Prepared:
5/23/2018 10:37 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	2,475,651	0		1.00
2.00	2,335,030	0		2.00
3.00	-10,648,522	0		3.00
4.00	308,241	9		4.00
4.01	829,393	9		4.01
4.02	0	0		4.02
4.03	0	0		4.03
5.00	-4,700,207			5.00

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

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

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

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

6.00	HEALTH CARE		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: 14-0048

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2018 10:37 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,817,110	1,817,110	0	0	1	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	557,382	557,382	0	0	1	2.00
3.00	53.00	ANESTHESIOLOGY	1,616,519	1,616,519	0	0	1	3.00
4.00	66.00	PHYSICAL THERAPY	24,225	24,225	0	0	1	4.00
5.00	0.00		0	0	0	0	1	5.00
6.00	0.00		0	0	0	0	1	6.00
7.00	0.00		0	0	0	0	1	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			4,015,236	4,015,236	0	0	7	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,817,110	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	557,382	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	1,616,519	3.00
4.00	66.00	PHYSICAL THERAPY	0	0	0	24,225	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	4,015,236	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	6,203,643	6,203,643			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	4,017,869		4,017,869		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,668,884	77,104	49,937	12,795,925	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,668,133	727,558	471,212	1,510,732	5.00
7.00 00700	OPERATION OF PLANT	8,303,062	1,033,235	669,188	548,398	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	550,913	0	0	0	8.00
9.00 00900	HOUSEKEEPING	2,082,346	142,059	92,006	307,169	9.00
10.00 01000	DIETARY	1,754,999	173,431	112,325	184,189	10.00
11.00 01100	CAFETERIA	572,307	101,864	65,974	108,174	11.00
13.00 01300	NURSING ADMINISTRATION	2,589,341	73,924	47,878	527,170	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	3,611,912	85,020	55,065	635,208	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	44,737	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,802,673	1,384,327	896,579	3,586,626	30.00
31.00 03100	INTENSIVE CARE UNIT	4,920,812	462,453	299,514	975,021	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	824,834	42,552	27,560	181,816	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,782,778	622,788	403,356	870,088	50.00
51.00 05100	RECOVERY ROOM	502,858	0	0	111,957	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	58,162	0	0	5,701	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,991,672	163,366	105,806	1,010,988	54.00
56.00 05600	RADIOISOTOPE	309,764	192,675	124,788	63,148	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	-25,619	41,078	26,605	2,173	59.00
60.00 06000	LABORATORY	5,422,121	144,775	93,765	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	1,298,108	51,438	33,314	285,985	65.00
66.00 06600	PHYSICAL THERAPY	1,205,554	116,919	75,724	260,839	66.00
67.00 06700	OCCUPATIONAL THERAPY	298,591	9,306	6,027	66,610	67.00
68.00 06800	SPEECH PATHOLOGY	109,259	2,885	1,868	24,397	68.00
69.00 06900	ELECTROCARDIOLOGY	769,716	57,565	37,282	160,435	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	51,075	2,653	1,718	11,264	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,671,258	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	3,099,594	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,215,005	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	742,206	43,900	28,432	147,004	74.00
76.00 03140	CARDIOLOGY	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	201,361	53,543	34,678	44,327	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	795,614	36,215	23,455	120,924	90.00
91.00 09100	EMERGENCY	9,120,959	329,954	213,699	1,035,818	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	134,236,501	6,172,587	3,997,755	12,786,161	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	NONREIM PARAMED RT	0	0	0	0	192.01
194.00 07951	NONREIMBURSABLE COST CENTERS	130,354	31,056	20,114	9,764	194.00
200.00	Cross Foot Adjustments	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118 through 201)	134,366,855	6,203,643	4,017,869	12,795,925	134,366,855	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/23/2018 10:37 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,377,635				5.00
7.00	00700	OPERATION OF PLANT	2,222,964	12,776,847			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	116,039	0	666,952		8.00
9.00	00900	HOUSEKEEPING	552,605	415,750	0	3,591,935	9.00
10.00	01000	DIETARY	468,640	507,564	0	147,490	3,348,638
11.00	01100	CAFETERIA	178,681	298,118	0	86,628	1,930,535
13.00	01300	NURSING ADMINISTRATION	682,086	216,348	0	62,867	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	924,077	248,822	0	72,304	0
16.00	01600	MEDICAL RECORDS & LIBRARY	9,423	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,985,631	4,051,390	212,741	1,177,269	1,103,711
31.00	03100	INTENSIVE CARE UNIT	1,402,332	1,353,422	40,478	393,283	314,392
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	226,798	124,534	48,309	36,188	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,406,800	1,822,658	52,322	529,635	0
51.00	05100	RECOVERY ROOM	129,498	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	13,451	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,321,036	478,110	109,274	138,931	0
56.00	05600	RADIOISOTOPE	145,414	563,885	0	163,856	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	9,318	120,221	14,819	34,934	0
60.00	06000	LABORATORY	1,192,305	423,699	6,764	123,120	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	351,509	150,538	0	43,744	0
66.00	06600	PHYSICAL THERAPY	349,443	342,176	7,474	99,431	0
67.00	06700	OCCUPATIONAL THERAPY	80,152	27,236	0	7,914	0
68.00	06800	SPEECH PATHOLOGY	29,153	8,442	0	2,453	0
69.00	06900	ELECTROCARDIOLOGY	215,895	168,469	13,729	48,954	0
70.00	07000	ELECTROENCEPHALOGRAPHY	14,051	7,764	0	2,256	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,615,797	0	12	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	652,867	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,309,067	0	0	0	0
74.00	07400	RENAL DIALYSIS	202,530	128,478	0	37,334	0
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	70,331	156,700	2,079	45,534	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	205,619	105,986	0	30,798	0
91.00	09100	EMERGENCY	2,253,832	965,647	158,951	280,601	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	23,337,344	12,685,957	666,952	3,565,524	3,348,638
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0
194.00	07951	NONREIMBURSABLE COST CENTERS	40,291	90,890	0	26,411	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	23,377,635	12,776,847	666,952	3,591,935	3,348,638

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

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

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	3,342,281				11.00
13.00	01300	NURSING ADMINISTRATION	173,810	4,373,424			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0		14.00
15.00	01500	PHARMACY	209,431	0	0	5,841,839	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,182,509	2,329,098	0	192,281	30.00
31.00	03100	INTENSIVE CARE UNIT	321,468	570,278	0	77,740	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	59,946	78,906	0	581	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	286,872	522,154	0	151,880	50.00
51.00	05100	RECOVERY ROOM	36,913	44,743	0	5,130	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,880	6,717	0	7,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	333,327	53,697	0	8,471	54.00
56.00	05600	RADIOISOTOPE	20,820	38	0	1,216	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	716	838	0	14,831	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	94,290	641	0	0	65.00
66.00	06600	PHYSICAL THERAPY	86,000	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,961	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,044	221	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	52,896	33,994	0	2,268	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,714	3,099	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,132,084	73.00
74.00	07400	RENAL DIALYSIS	48,468	68,515	0	5,126	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	14,615	8,427	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	39,869	9,044	0	6,368	90.00
91.00	09100	EMERGENCY	341,513	639,387	0	236,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	10,425	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,339,062	4,369,797	0	5,841,839	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	3,219	3,627	0	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)	3,342,281	4,373,424	0	5,841,839	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

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

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Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
		17.00	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE	0			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	0	38,928,065	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	11,131,300	0 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0 34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0 42.00
43.00 04300	NURSERY	0	0	1,654,078	0 43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	0	11,460,764	0 50.00
51.00 05100	RECOVERY ROOM	0	0	831,099	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	93,447	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	8,721,024	0 54.00
56.00 05600	RADIOISOTOPE	0	0	1,585,604	0 56.00
57.00 05700	CT SCAN	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	239,914	0 59.00
60.00 06000	LABORATORY	0	0	7,407,814	0 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0 60.01
65.00 06500	RESPIRATORY THERAPY	0	0	2,309,567	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	2,543,619	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	517,797	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	186,722	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	1,561,719	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	97,636	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9,287,067	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	3,752,461	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	12,656,156	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	1,451,993	0 74.00
76.00 03140	CARDIOLOGY	0	0	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	631,595	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0 89.00
90.00 09000	CLINIC	0	0	1,373,981	0 90.00
91.00 09100	EMERGENCY	0	0	15,587,113	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910	CORF	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS					
109.00 10900	PANCREAS ACQUISITION	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0 111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	134,010,535	0 118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0 192.00
192.01 19201	NONREIM PARAMED RT	0	0	0	0 192.01
194.00 07951	NONREIMBURSABLE COST CENTERS	0	0	356,320	0 194.00
200.00	Cross Foot Adjustments		0	0	0 200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0048

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

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Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	17.00	21.00	22.00	24.00	25.00	
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	134,366,855	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/23/2018 10:37 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	38,928,065	30.00
31.00	03100 INTENSIVE CARE UNIT	11,131,300	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	1,654,078	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	11,460,764	50.00
51.00	05100 RECOVERY ROOM	831,099	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	93,447	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,721,024	54.00
56.00	05600 RADIOISOTOPE	1,585,604	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	239,914	59.00
60.00	06000 LABORATORY	7,407,814	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	2,309,567	65.00
66.00	06600 PHYSICAL THERAPY	2,543,619	66.00
67.00	06700 OCCUPATIONAL THERAPY	517,797	67.00
68.00	06800 SPEECH PATHOLOGY	186,722	68.00
69.00	06900 ELECTROCARDIOLOGY	1,561,719	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	97,636	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,287,067	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,752,461	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,656,156	73.00
74.00	07400 RENAL DIALYSIS	1,451,993	74.00
76.00	03140 CARDIOLOGY	0	76.00
76.97	07697 CARDIAC REHABILITATION	631,595	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	1,373,981	90.00
91.00	09100 EMERGENCY	15,587,113	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	134,010,535	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 NONREIM PARAMED RT	0	192.01
194.00	07951 NONREIMBURSABLE COST CENTERS	356,320	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	134,366,855	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

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

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	77,104	49,937	127,041	127,041
5.00 00500	ADMINISTRATIVE & GENERAL	0	727,558	471,212	1,198,770	14,999
7.00 00700	OPERATION OF PLANT	0	1,033,235	669,188	1,702,423	5,445
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00 00900	HOUSEKEEPING	0	142,059	92,006	234,065	3,050
10.00 01000	DIETARY	0	173,431	112,325	285,756	1,829
11.00 01100	CAFETERIA	0	101,864	65,974	167,838	1,074
13.00 01300	NURSING ADMINISTRATION	0	73,924	47,878	121,802	5,234
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	0	85,020	55,065	140,085	6,307
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,384,327	896,579	2,280,906	35,605
31.00 03100	INTENSIVE CARE UNIT	0	462,453	299,514	761,967	9,680
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	42,552	27,560	70,112	1,805
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	622,788	403,356	1,026,144	8,639
51.00 05100	RECOVERY ROOM	0	0	0	0	1,112
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	57
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	163,366	105,806	269,172	10,037
56.00 05600	RADIOISOTOPE	0	192,675	124,788	317,463	627
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	41,078	26,605	67,683	22
60.00 06000	LABORATORY	0	144,775	93,765	238,540	0
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	0	51,438	33,314	84,752	2,839
66.00 06600	PHYSICAL THERAPY	0	116,919	75,724	192,643	2,590
67.00 06700	OCCUPATIONAL THERAPY	0	9,306	6,027	15,333	661
68.00 06800	SPEECH PATHOLOGY	0	2,885	1,868	4,753	242
69.00 06900	ELECTROCARDIOLOGY	0	57,565	37,282	94,847	1,593
70.00 07000	ELECTROENCEPHALOGRAPHY	0	2,653	1,718	4,371	112
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	43,900	28,432	72,332	1,460
76.00 03140	CARDIOLOGY	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	53,543	34,678	88,221	440
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	0	36,215	23,455	59,670	1,201
91.00 09100	EMERGENCY	0	329,954	213,699	543,653	10,284
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	0	6,172,587	3,997,755	10,170,342	126,944
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01 19201	NONREIM PARAMED RT	0	0	0	0	0
194.00 07951	NONREIMBURSABLE COST CENTERS	0	31,056	20,114	51,170	97
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
202.00	TOTAL (sum lines 118 through 201)	0	1.00 6,203,643	2.00 4,017,869	2A 10,221,512	4.00 127,041	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 10:37 am			
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,213,769					5.00
7.00	00700	OPERATION OF PLANT	115,417	1,823,285				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,025	0	6,025			8.00
9.00	00900	HOUSEKEEPING	28,691	59,328	0	325,134		9.00
10.00	01000	DIETARY	24,332	72,431	0	13,350	397,698	10.00
11.00	01100	CAFETERIA	9,277	42,542	0	7,841	229,279	11.00
13.00	01300	NURSING ADMINISTRATION	35,414	30,873	0	5,691	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	47,978	35,507	0	6,545	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	489	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	258,849	578,144	1,921	106,564	131,081	30.00
31.00	03100	INTENSIVE CARE UNIT	72,810	193,136	366	35,599	37,338	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	11,775	17,771	436	3,276	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	73,042	260,097	473	47,941	0	50.00
51.00	05100	RECOVERY ROOM	6,724	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	698	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,589	68,227	987	12,576	0	54.00
56.00	05600	RADIOISOTOPE	7,550	80,468	0	14,832	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	484	17,156	134	3,162	0	59.00
60.00	06000	LABORATORY	61,905	60,463	61	11,145	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	18,250	21,482	0	3,960	0	65.00
66.00	06600	PHYSICAL THERAPY	18,143	48,829	68	9,000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,162	3,887	0	716	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,514	1,205	0	222	0	68.00
69.00	06900	ELECTROCARDIOLOGY	11,209	24,041	124	4,431	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	730	1,108	0	204	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,893	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	33,897	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,967	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,515	18,334	0	3,379	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	3,652	22,361	19	4,122	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	10,676	15,125	0	2,788	0	90.00
91.00	09100	EMERGENCY	117,020	137,800	1,436	25,399	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,211,677	1,810,315	6,025	322,743	397,698	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	2,092	12,970	0	2,391	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,213,769	1,823,285	6,025	325,134	397,698	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/23/2018 10:37 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	457,851					11.00
13.00	01300	NURSING ADMINISTRATION	23,810	222,824				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	28,690	0	0	265,112		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	489	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	161,985	118,665	0	8,726	210	30.00
31.00	03100	INTENSIVE CARE UNIT	44,038	29,055	0	3,528	1	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	8,212	4,020	0	26	19	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	39,298	26,604	0	6,893	85	50.00
51.00	05100	RECOVERY ROOM	5,057	2,280	0	233	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	258	342	0	342	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,662	2,736	0	384	57	54.00
56.00	05600	RADIOISOTOPE	2,852	2	0	55	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	98	43	0	673	0	59.00
60.00	06000	LABORATORY	0	0	0	0	11	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	12,917	33	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,781	0	0	0	1	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,008	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,102	11	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,246	1,732	0	103	5	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	509	158	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	232,902	0	73.00
74.00	07400	RENAL DIALYSIS	6,640	3,491	0	233	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,002	429	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	5,462	461	0	289	1	90.00
91.00	09100	EMERGENCY	46,783	32,577	0	10,725	94	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	457,410	222,639	0	265,112	484	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0	192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	441	185	0	0	5	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)	457,851	222,824	0	265,112	489	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 10:37 am
Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
	17.00	21.00	22.00	24.00	25.00
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0		0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,682,656	0 31.00
32.00	03200	CORONARY CARE UNIT	0	1,187,518	0 32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0 33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0 34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0 42.00
43.00	04300	NURSERY	0	117,452	0 43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,489,216	0 50.00
51.00	05100	RECOVERY ROOM	0	15,406	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,697	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	478,427	0 54.00
56.00	05600	RADIOISOTOPE	0	423,849	0 56.00
57.00	05700	CT SCAN	0	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	89,455	0 59.00
60.00	06000	LABORATORY	0	372,125	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0 60.01
65.00	06500	RESPIRATORY THERAPY	0	144,233	0 65.00
66.00	06600	PHYSICAL THERAPY	0	283,055	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	27,767	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	9,049	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	145,331	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,192	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	83,893	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	33,897	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	300,869	0 73.00
74.00	07400	RENAL DIALYSIS	0	116,384	0 74.00
76.00	03140	CARDIOLOGY	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	121,246	0 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0 89.00
90.00	09000	CLINIC	0	95,673	0 90.00
91.00	09100	EMERGENCY	0	925,771	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0 109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0 110.00
111.00	11100	ISLET ACQUISITION	0	0	0 111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0 118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0 192.00
192.01	19201	NONREIM PARAMED RT	0	0	0 192.01
194.00	07951	NONREIMBURSABLE COST CENTERS	0	69,351	0 194.00
200.00		Cross Foot Adjustments	0	0	0 200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0048

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

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
	17.00	21.00	22.00	24.00	25.00	
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	10,221,512	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 10:37 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	3,682,656	30.00
31.00	03100 INTENSIVE CARE UNIT	1,187,518	31.00
32.00	03200 CORONARY CARE UNIT	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	41.00
42.00	04200 SUBPROVIDER	0	42.00
43.00	04300 NURSERY	117,452	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	1,489,216	50.00
51.00	05100 RECOVERY ROOM	15,406	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300 ANESTHESIOLOGY	1,697	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	478,427	54.00
56.00	05600 RADIOISOTOPE	423,849	56.00
57.00	05700 CT SCAN	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	89,455	59.00
60.00	06000 LABORATORY	372,125	60.00
60.01	06001 BLOOD LABORATORY	0	60.01
65.00	06500 RESPIRATORY THERAPY	144,233	65.00
66.00	06600 PHYSICAL THERAPY	283,055	66.00
67.00	06700 OCCUPATIONAL THERAPY	27,767	67.00
68.00	06800 SPEECH PATHOLOGY	9,049	68.00
69.00	06900 ELECTROCARDIOLOGY	145,331	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	7,192	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	83,893	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	33,897	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	300,869	73.00
74.00	07400 RENAL DIALYSIS	116,384	74.00
76.00	03140 RADIOLOGY	0	76.00
76.97	07697 CARDIAC REHABILITATION	121,246	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000 CLINIC	95,673	90.00
91.00	09100 EMERGENCY	925,771	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10	09910 CORF	0	99.10
SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	110.00
111.00	11100 ISLET ACQUISITION	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	10,152,161	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 NONREIM PARAMED RT	0	192.01
194.00	07951 NONREIMBURSABLE COST CENTERS	69,351	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	10,221,512	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQ. FEET OLD)	NEW MVBLE EQUIP (SQ. FEET OLD)				
	1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	294,639				1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		294,639			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,662	3,662	52,934,364		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	34,555	34,555	6,249,617	-23,377,635	5.00
7.00 00700	OPERATION OF PLANT	49,073	49,073	2,268,619	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	6,747	6,747	1,270,701	0	9.00
10.00 01000	DIETARY	8,237	8,237	761,955	0	10.00
11.00 01100	CAFETERIA	4,838	4,838	447,497	0	11.00
13.00 01300	NURSING ADMINISTRATION	3,511	3,511	2,180,803	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	4,038	4,038	2,627,737	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	65,748	65,748	14,837,214	0	30.00
31.00 03100	INTENSIVE CARE UNIT	21,964	21,964	4,033,481	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	2,021	2,021	752,140	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	29,579	29,579	3,599,392	0	50.00
51.00 05100	RECOVERY ROOM	0	0	463,144	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	23,585	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	7,759	7,759	4,182,269	0	54.00
56.00 05600	RADIOISOTOPE	9,151	9,151	261,231	0	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,951	1,951	8,989	0	59.00
60.00 06000	LABORATORY	6,876	6,876	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	2,443	2,443	1,183,066	0	65.00
66.00 06600	PHYSICAL THERAPY	5,553	5,553	1,079,044	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	442	442	275,552	0	67.00
68.00 06800	SPEECH PATHOLOGY	137	137	100,927	0	68.00
69.00 06900	ELECTROCARDIOLOGY	2,734	2,734	663,691	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	126	126	46,595	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	2,085	2,085	608,130	0	74.00
76.00 03140	CARDIOLOGY	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	2,543	2,543	183,371	0	76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	1,720	1,720	500,239	0	90.00
91.00 09100	EMERGENCY	15,671	15,671	4,284,984	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	293,164	293,164	52,893,973	-23,377,635	110,797,932
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	NONREIM PARAMED RT	0	0	0	0	192.01
194.00 07951	NONREIMBURSABLE COST CENTERS	1,475	1,475	40,391	0	194.00
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQ. FEET OLD)	NEW MVBLE EQUIP (SQ. FEET OLD)				
	1.00	2.00				
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		12,795,925		23,377,635	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		0.241732		0.210630	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		127,041		1,213,769	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.002400		0.010936	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description		OPERATION OF PLANT (SQ. FEET OLD)	LAUNDRY & LINEN SERVICE (LAUNDRY LBS)	HOUSEKEEPING (SQ. FEET OLD)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	207,349				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	859,208			8.00
9.00	00900	HOUSEKEEPING	6,747	0	200,602		9.00
10.00	01000	DIETARY	8,237	0	8,237	339,463	10.00
11.00	01100	CAFETERIA	4,838	0	4,838	195,705	41,935,975
13.00	01300	NURSING ADMINISTRATION	3,511	0	3,511	0	2,180,803
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00	01500	PHARMACY	4,038	0	4,038	0	2,627,737
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,748	274,066	65,748	111,887	14,837,214
31.00	03100	INTENSIVE CARE UNIT	21,964	52,146	21,964	31,871	4,033,481
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	2,021	62,234	2,021	0	752,140
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	29,579	67,404	29,579	0	3,599,392
51.00	05100	RECOVERY ROOM	0	0	0	0	463,144
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	23,585
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,759	140,773	7,759	0	4,182,269
56.00	05600	RADIOISOTOPE	9,151	0	9,151	0	261,231
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	1,951	19,091	1,951	0	8,989
60.00	06000	LABORATORY	6,876	8,714	6,876	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	2,443	0	2,443	0	1,183,066
66.00	06600	PHYSICAL THERAPY	5,553	9,629	5,553	0	1,079,044
67.00	06700	OCCUPATIONAL THERAPY	442	0	442	0	275,552
68.00	06800	SPEECH PATHOLOGY	137	0	137	0	100,927
69.00	06900	ELECTROCARDIOLOGY	2,734	17,687	2,734	0	663,691
70.00	07000	ELECTROENCEPHALOGRAPHY	126	0	126	0	46,595
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	2,085	0	2,085	0	608,130
76.00	03140	CARDIOLOGY	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	2,543	2,678	2,543	0	183,371
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	1,720	0	1,720	0	500,239
91.00	09100	EMERGENCY	15,671	204,771	15,671	0	4,284,984
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	205,874	859,208	199,127	339,463	41,895,584
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	NONREIM PARAMED RT	0	0	0	0	0
194.00	07951	NONREIMBURSABLE COST CENTERS	1,475	0	1,475	0	40,391
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	12,776,847	666,952	3,591,935	3,348,638	3,342,281

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description		OPERATION OF PLANT (SQ. FEET OLD)	LAUNDRY & LINEN SERVICE (LAUNDRY LBS)	HOUSEKEEPING (SQ. FEET OLD)	DIETARY (MEALS SERVED)	CAFETERIA (GROSS SALARIES)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	61.620008	0.776240	17.905779	9.864515	0.079700	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,823,285	6,025	325,134	397,698	457,851	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	8.793315	0.007012	1.620791	1.171550	0.010918	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description		NURSING ADMINISTRATION (NSG FTE)	CENTRAL SERVICES & SUPPLY (MED SUPPL COSTS)	PHARMACY (PHARM COSTS)	MEDICAL RECORDS & LIBRARY (MED REC TIME)	SOCIAL SERVICE (SOC SERV TIME)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	928,493					13.00
14.00	01400	0	0				14.00
15.00	01500	0	0	6,172,041			15.00
16.00	01600	0	0	0	9,123		16.00
17.00	01700	0	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	494,476	0	203,149	3,913	0	30.00
31.00	03100	121,072	0	82,134	18	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	16,752	0	614	346	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	110,855	0	160,465	1,589	0	50.00
51.00	05100	9,499	0	5,420	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	1,426	0	7,962	0	0	53.00
54.00	05400	11,400	0	8,950	1,069	0	54.00
56.00	05600	8	0	1,285	0	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	178	0	15,669	0	0	59.00
60.00	06000	0	0	0	213	0	60.00
60.01	06001	0	0	0	0	0	60.01
65.00	06500	136	0	0	0	0	65.00
66.00	06600	0	0	0	10	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	47	0	0	0	0	68.00
69.00	06900	7,217	0	2,396	87	0	69.00
70.00	07000	658	0	0	7	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	5,422,168	0	0	73.00
74.00	07400	14,546	0	5,416	0	0	74.00
76.00	03140	0	0	0	0	0	76.00
76.97	07697	1,789	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,920	0	6,728	15	0	90.00
91.00	09100	135,744	0	249,685	1,756	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		927,723	0	6,172,041	9,023	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07951	770	0	0	100	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (MED SUPPL COSTS)	PHARMACY (PHARM COSTS)	MEDICAL RECORDS & LIBRARY (MED REC TIME)	SOCIAL SERVICE (SOC SERV TIME)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	4,373,424	0	5,841,839	54,160	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4.710239	0.000000	0.946500	5.936644	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	222,824	0	265,112	489	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.239985	0.000000	0.042954	0.053601	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES (HRS)	SERVICES-OTHER PRGM COSTS (HRS)		
	21.00	22.00		
GENERAL SERVICE COST CENTERS				
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 00500	ADMINISTRATIVE & GENERAL			5.00
7.00 00700	OPERATION OF PLANT			7.00
8.00 00800	LAUNDRY & LINEN SERVICE			8.00
9.00 00900	HOUSEKEEPING			9.00
10.00 01000	DIETARY			10.00
11.00 01100	CAFETERIA			11.00
13.00 01300	NURSING ADMINISTRATION			13.00
14.00 01400	CENTRAL SERVICES & SUPPLY			14.00
15.00 01500	PHARMACY			15.00
16.00 01600	MEDICAL RECORDS & LIBRARY			16.00
17.00 01700	SOCIAL SERVICE			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000	ADULTS & PEDIATRICS	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	31.00
32.00 03200	CORONARY CARE UNIT	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00 04100	SUBPROVIDER - IRF	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	42.00
43.00 04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000	OPERATING ROOM	0	0	50.00
51.00 05100	RECOVERY ROOM	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600	RADIOISOTOPE	0	0	56.00
57.00 05700	CT SCAN	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	60.01
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
76.00 03140	CARDIOLOGY	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800	RURAL HEALTH CLINIC	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000	CLINIC	0	0	90.00
91.00 09100	EMERGENCY	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00 10900	PANCREAS ACQUISITION	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01 19201	NONREIM PARAMED RT	0	0	192.01
194.00 07951	NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0048

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description	INTERNS & RESIDENTS			
	SERVICES-SALARY & FRINGES (HRS)	SERVICES-OTHER PRGM COSTS (HRS)		
	21.00	22.00		
202.00 Cost to be allocated (per Wkst. B, Part I)	0	0		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0		204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 10:37 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	38,928,065		38,928,065	0	38,928,065	30.00
31.00	03100 INTENSIVE CARE UNIT	11,131,300		11,131,300	0	11,131,300	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,654,078		1,654,078	0	1,654,078	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,460,764		11,460,764	0	11,460,764	50.00
51.00	05100 RECOVERY ROOM	831,099		831,099	0	831,099	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	93,447		93,447	0	93,447	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,721,024		8,721,024	0	8,721,024	54.00
56.00	05600 RADIOISOTOPE	1,585,604		1,585,604	0	1,585,604	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	239,914		239,914	0	239,914	59.00
60.00	06000 LABORATORY	7,407,814		7,407,814	0	7,407,814	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	2,309,567	0	2,309,567	0	2,309,567	65.00
66.00	06600 PHYSICAL THERAPY	2,543,619	0	2,543,619	0	2,543,619	66.00
67.00	06700 OCCUPATIONAL THERAPY	517,797	0	517,797	0	517,797	67.00
68.00	06800 SPEECH PATHOLOGY	186,722	0	186,722	0	186,722	68.00
69.00	06900 ELECTROCARDIOLOGY	1,561,719		1,561,719	0	1,561,719	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	97,636		97,636	0	97,636	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,287,067		9,287,067	0	9,287,067	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,752,461		3,752,461	0	3,752,461	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,656,156		12,656,156	0	12,656,156	73.00
74.00	07400 RENAL DIALYSIS	1,451,993		1,451,993	0	1,451,993	74.00
76.00	03140 RADIOLOGY	0		0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	631,595		631,595	0	631,595	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	1,373,981		1,373,981	0	1,373,981	90.00
91.00	09100 EMERGENCY	15,587,113		15,587,113	0	15,587,113	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8,253,775		8,253,775	0	8,253,775	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100 ISLET ACQUISITION	0		0		0	111.00
200.00	Subtotal (see instructions)	142,264,310	0	142,264,310	0	142,264,310	200.00
201.00	Less Observation Beds	8,253,775		8,253,775		8,253,775	201.00
202.00	Total (see instructions)	134,010,535	0	134,010,535	0	134,010,535	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 10:37 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,414,712		65,414,712		30.00
31.00	03100	INTENSIVE CARE UNIT	23,936,216		23,936,216		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	1,791,710		1,791,710		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,678,860	31,471,008	43,149,868	0.265604	50.00
51.00	05100	RECOVERY ROOM	2,295,361	4,551,318	6,846,679	0.121387	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,340,262	3,054,118	5,394,380	0.177323	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,289,219	54,938,038	81,227,257	0.107366	54.00
56.00	05600	RADIOISOTOPE	2,908,259	4,376,407	7,284,666	0.217663	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,982,164	1,624,556	7,606,720	0.031540	59.00
60.00	06000	LABORATORY	30,372,150	19,986,224	50,358,374	0.147102	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	13,729,409	2,696,559	16,425,968	0.140605	65.00
66.00	06600	PHYSICAL THERAPY	2,417,668	3,501,002	5,918,670	0.429762	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,319,208	494,362	1,813,570	0.285513	67.00
68.00	06800	SPEECH PATHOLOGY	745,710	187,817	933,527	0.200018	68.00
69.00	06900	ELECTROCARDIOLOGY	5,901,661	5,628,537	11,530,198	0.135446	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	478,720	195,700	674,420	0.144770	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,327,367	3,363,809	7,691,176	1.207496	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,191,006	3,429,980	8,620,986	0.435271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,590,790	21,234,316	60,825,106	0.208075	73.00
74.00	07400	RENAL DIALYSIS	4,012,779	0	4,012,779	0.361842	74.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	32,430	974,641	1,007,071	0.627160	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	2,177,079	2,177,079	0.631112	90.00
91.00	09100	EMERGENCY	15,463,239	60,681,731	76,144,970	0.204703	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,826,414	9,340,251	13,166,665	0.626869	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	270,045,314	233,907,453	503,952,767		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	270,045,314	233,907,453	503,952,767		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
32.00	03200 CORONARY CARE UNIT			32.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.265604		50.00
51.00	05100 RECOVERY ROOM	0.121387		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.017323		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.107366		54.00
56.00	05600 RADIOISOTOPE	0.217663		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.031540		59.00
60.00	06000 LABORATORY	0.147102		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.140605		65.00
66.00	06600 PHYSICAL THERAPY	0.429762		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.285513		67.00
68.00	06800 SPEECH PATHOLOGY	0.200018		68.00
69.00	06900 ELECTROCARDIOLOGY	0.135446		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.144770		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.207496		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.435271		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.208075		73.00
74.00	07400 RENAL DIALYSIS	0.361842		74.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.627160		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.631112		90.00
91.00	09100 EMERGENCY	0.204703		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.626869		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 14-0048

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 10:37 am

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	38,928,065		38,928,065	0	38,928,065	30.00
31.00	03100 INTENSIVE CARE UNIT	11,131,300		11,131,300	0	11,131,300	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,654,078		1,654,078	0	1,654,078	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	11,460,764		11,460,764	0	11,460,764	50.00
51.00	05100 RECOVERY ROOM	831,099		831,099	0	831,099	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	93,447		93,447	0	93,447	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,721,024		8,721,024	0	8,721,024	54.00
56.00	05600 RADIOISOTOPE	1,585,604		1,585,604	0	1,585,604	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	239,914		239,914	0	239,914	59.00
60.00	06000 LABORATORY	7,407,814		7,407,814	0	7,407,814	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
65.00	06500 RESPIRATORY THERAPY	2,309,567	0	2,309,567	0	2,309,567	65.00
66.00	06600 PHYSICAL THERAPY	2,543,619	0	2,543,619	0	2,543,619	66.00
67.00	06700 OCCUPATIONAL THERAPY	517,797	0	517,797	0	517,797	67.00
68.00	06800 SPEECH PATHOLOGY	186,722	0	186,722	0	186,722	68.00
69.00	06900 ELECTROCARDIOLOGY	1,561,719		1,561,719	0	1,561,719	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	97,636		97,636	0	97,636	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9,287,067		9,287,067	0	9,287,067	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3,752,461		3,752,461	0	3,752,461	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,656,156		12,656,156	0	12,656,156	73.00
74.00	07400 RENAL DIALYSIS	1,451,993		1,451,993	0	1,451,993	74.00
76.00	03140 RADIOLOGY	0		0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	631,595		631,595	0	631,595	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	1,373,981		1,373,981	0	1,373,981	90.00
91.00	09100 EMERGENCY	15,587,113		15,587,113	0	15,587,113	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8,253,775		8,253,775	0	8,253,775	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0		0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100 ISLET ACQUISITION	0		0		0	111.00
200.00	Subtotal (see instructions)	142,264,310	0	142,264,310	0	142,264,310	200.00
201.00	Less Observation Beds	8,253,775		8,253,775		8,253,775	201.00
202.00	Total (see instructions)	134,010,535	0	134,010,535	0	134,010,535	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0048

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 10:37 am

		Title XIX			Hospital	Cost		
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	65,414,712		65,414,712			30.00
31.00	03100	INTENSIVE CARE UNIT	23,936,216		23,936,216			31.00
32.00	03200	CORONARY CARE UNIT	0		0			32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	1,791,710		1,791,710			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,678,860	31,471,008	43,149,868	0.265604	0.000000	50.00
51.00	05100	RECOVERY ROOM	2,295,361	4,551,318	6,846,679	0.121387	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,340,262	3,054,118	5,394,380	0.017323	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,289,219	54,938,038	81,227,257	0.107366	0.000000	54.00
56.00	05600	RADIOISOTOPE	2,908,259	4,376,407	7,284,666	0.217663	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,982,164	1,624,556	7,606,720	0.031540	0.000000	59.00
60.00	06000	LABORATORY	30,372,150	19,986,224	50,358,374	0.147102	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	13,729,409	2,696,559	16,425,968	0.140605	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,417,668	3,501,002	5,918,670	0.429762	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,319,208	494,362	1,813,570	0.285513	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	745,710	187,817	933,527	0.200018	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,901,661	5,628,537	11,530,198	0.135446	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	478,720	195,700	674,420	0.144770	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,327,367	3,363,809	7,691,176	1.207496	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,191,006	3,429,980	8,620,986	0.435271	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	39,590,790	21,234,316	60,825,106	0.208075	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,012,779	0	4,012,779	0.361842	0.000000	74.00
76.00	03140	CARDIOLOGY	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	32,430	974,641	1,007,071	0.627160	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	2,177,079	2,177,079	0.631112	0.000000	90.00
91.00	09100	EMERGENCY	15,463,239	60,681,731	76,144,970	0.204703	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,826,414	9,340,251	13,166,665	0.626869	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	270,045,314	233,907,453	503,952,767			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	270,045,314	233,907,453	503,952,767			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/23/2018 10:37 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
32.00	03200 CORONARY CARE UNIT			32.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
76.00	03140 RADIOLOGY	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Prepared: 5/23/2018 10:37 am
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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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,682,656	0	3,682,656	28,303	130.12	30.00
31.00	INTENSIVE CARE UNIT	1,187,518		1,187,518	6,354	186.89	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	117,452		117,452	1,846	63.63	43.00
200.00	Total (lines 30 through 199)	4,987,626		4,987,626	36,503		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	6,548	852,026				
31.00	INTENSIVE CARE UNIT	1,957	365,744				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	8,505	1,217,770				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/23/2018 10:37 am
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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	1,489,216	43,149,868	0.034513	3,189,418	110,076	50.00
51.00	05100	RECOVERY ROOM	15,406	6,846,679	0.002250	595,951	1,341	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,697	5,394,380	0.000315	477,268	150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	478,427	81,227,257	0.005890	8,126,667	47,866	54.00
56.00	05600	RADIOISOTOPE	423,849	7,284,666	0.058184	822,683	47,867	56.00
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	89,455	7,606,720	0.011760	1,490,135	17,524	59.00
60.00	06000	LABORATORY	372,125	50,358,374	0.007390	8,415,944	62,194	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	144,233	16,425,968	0.008781	4,294,276	37,708	65.00
66.00	06600	PHYSICAL THERAPY	283,055	5,918,670	0.047824	841,080	40,224	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,767	1,813,570	0.015311	454,655	6,961	67.00
68.00	06800	SPEECH PATHOLOGY	9,049	933,527	0.009693	287,581	2,788	68.00
69.00	06900	ELECTROCARDIOLOGY	145,331	11,530,198	0.012604	1,839,373	23,183	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,192	674,420	0.010664	167,322	1,784	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,893	7,691,176	0.010908	1,340,899	14,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	33,897	8,620,986	0.003932	1,451,594	5,708	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	300,869	60,825,106	0.004946	10,807,880	53,456	73.00
74.00	07400	RENAL DIALYSIS	116,384	4,012,779	0.029003	1,420,189	41,190	74.00
76.00	03140	CARDIOLOGY	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	121,246	1,007,071	0.120395	5,904	711	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	95,673	2,177,079	0.043946	0	0	90.00
91.00	09100	EMERGENCY	925,771	76,144,970	0.012158	4,507,461	54,802	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	780,824	13,166,665	0.059303	1,280,497	75,937	92.00
200.00		Total (lines 50 through 199)	5,945,359	412,810,129		51,816,777	646,097	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/23/2018 10:37 am
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS
Title XVIII		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
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
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	
Title XVIII		4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	28,303	0.00	6,548
31.00	03100	INTENSIVE CARE UNIT	0	0	6,354	0.00	1,957
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0
42.00	04200	SUBPROVIDER	0	0	0	0.00	0
43.00	04300	NURSERY	0	0	1,846	0.00	0
200.00		Total (lines 30 through 199)	0	0	36,503		8,505
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
Title XVIII		9.00					
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0				31.00
32.00	03200	CORONARY CARE UNIT	0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0				34.00
41.00	04100	SUBPROVIDER - IRF	0				41.00
42.00	04200	SUBPROVIDER	0				42.00
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: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 10:37 am
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Cost Center Description	Title XVIII					Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	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
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	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: 14-0048

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description		Title XVIII		Hospital		PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	43,149,868	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,846,679	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,394,380	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	81,227,257	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	7,284,666	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	7,606,720	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	50,358,374	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	0	16,425,968	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,918,670	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,813,570	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	933,527	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	11,530,198	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	674,420	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7,691,176	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	8,620,986	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	60,825,106	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,012,779	0.000000	74.00
76.00	03140	CARDIOLOGY	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,007,071	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	2,177,079	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	76,144,970	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	13,166,665	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	412,810,129		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 10:37 am
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Cost Center Description		Title XVIII				Hospital		
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS	
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	3,189,418	0	4,681,353	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	595,951	0	607,785	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	477,268	0	419,231	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	8,126,667	0	8,749,714	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	822,683	0	1,083,579	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,490,135	0	400,858	0	59.00
60.00	06000	LABORATORY	0.000000	8,415,944	0	2,733,846	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.000000	4,294,276	0	488,300	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	841,080	0	153,444	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	454,655	0	29,481	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	287,581	0	8,328	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,839,373	0	1,103,564	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	167,322	0	42,966	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1,340,899	0	751,962	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,451,594	0	728,962	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,807,880	0	3,620,203	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,420,189	0	0	0	74.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	5,904	0	253,223	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	635,902	0	90.00
91.00	09100	EMERGENCY	0.000000	4,507,461	0	6,444,895	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,280,497	0	3,244,246	0	92.00
200.00		Total (lines 50 through 199)		51,816,777	0	36,181,842	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.265604	4,681,353	0	132	1,243,386	50.00
51.00	05100	RECOVERY ROOM	0.121387	607,785	0	0	73,777	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.017323	419,231	0	0	7,262	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107366	8,749,714	0	981	939,422	54.00
56.00	05600	RADIOISOTOPE	0.217663	1,083,579	0	0	235,855	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.031540	400,858	0	20	12,643	59.00
60.00	06000	LABORATORY	0.147102	2,733,846	0	0	402,154	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.140605	488,300	0	0	68,657	65.00
66.00	06600	PHYSICAL THERAPY	0.429762	153,444	0	0	65,944	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285513	29,481	0	0	8,417	67.00
68.00	06800	SPEECH PATHOLOGY	0.200018	8,328	0	0	1,666	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135446	1,103,564	0	0	149,473	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.144770	42,966	0	0	6,220	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.207496	751,962	0	0	907,991	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.435271	728,962	0	0	317,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208075	3,620,203	0	26,290	753,274	73.00
74.00	07400	RENAL DIALYSIS	0.361842	0	0	0	0	74.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.627160	253,223	0	0	158,811	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.631112	635,902	0	568	401,325	90.00
91.00	09100	EMERGENCY	0.204703	6,444,895	0	0	1,319,289	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.626869	3,244,246	0	0	2,033,717	92.00
200.00		Subtotal (see instructions)		36,181,842	0	27,991	9,106,579	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		36,181,842	0	27,991	9,106,579	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	35	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	105	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,470	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	358	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	5,969	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	5,969	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 10:37 am
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		Title XIX		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.265604	0	0	402,178	0	50.00
51.00	05100	RECOVERY ROOM	0.121387	0	0	87,265	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.017323	0	0	49,765	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107366	0	0	2,738,435	0	54.00
56.00	05600	RADIOISOTOPE	0.217663	0	0	141,807	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.031540	0	0	10,140	0	59.00
60.00	06000	LABORATORY	0.147102	0	0	1,255,812	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.140605	0	0	130,275	0	65.00
66.00	06600	PHYSICAL THERAPY	0.429762	0	0	63,478	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285513	0	0	11,250	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.200018	0	0	5,540	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135446	0	0	231,535	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.144770	0	0	6,430	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.207496	0	0	100,667	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.435271	0	0	34,051	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208075	0	0	572,095	0	73.00
74.00	07400	RENAL DIALYSIS	0.361842	0	0	0	0	74.00
76.00	03140	CARDIOLOGY	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.627160	0	0	12,379	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.631112	0	0	26,270	0	90.00
91.00	09100	EMERGENCY	0.204703	0	0	4,841,255	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.626869	0	0	666,218	0	92.00
200.00		Subtotal (see instructions)		0	0	11,386,845	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	11,386,845	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 10:37 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	106,820	50.00
51.00	05100	RECOVERY ROOM	0	10,593	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	862	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	294,015	54.00
56.00	05600	RADIOISOTOPE	0	30,866	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	320	59.00
60.00	06000	LABORATORY	0	184,732	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
65.00	06500	RESPIRATORY THERAPY	0	18,317	65.00
66.00	06600	PHYSICAL THERAPY	0	27,280	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,212	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,108	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,360	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	931	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	121,555	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	14,821	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	119,039	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03140	CARDIOLOGY	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	7,764	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	16,579	90.00
91.00	09100	EMERGENCY	0	991,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	417,631	92.00
200.00		Subtotal (see instructions)	0	2,398,824	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	2,398,824	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/23/2018 10:37 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,303	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,303	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)		22,302	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)		6,548	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		38,928,065	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)		38,928,065	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		38,928,065	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,375.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,006,119	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)		9,006,119	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
Date/Time Prepared: 5/23/2018 10:37 am		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	11,131,300	6,354	1,751.86	1,957	3,428,390		43.00
44.00 CORONARY CARE UNIT	0	0	0.00	0	0		44.00
45.00 BURN INTENSIVE CARE UNIT	0	0	0.00	0	0		45.00
46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0		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)					11,433,078		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,867,587		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)					1,217,770		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					646,097		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,863,867		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,003,720		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)					6,001		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,375.40		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					8,253,775		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 10:37 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,682,656	38,928,065	0.094602	8,253,775	780,824	90.00
91.00	Nursing School cost	0	38,928,065	0.000000	8,253,775	0	91.00
92.00	Allied health cost	0	38,928,065	0.000000	8,253,775	0	92.00
93.00	All other Medical Education	0	38,928,065	0.000000	8,253,775	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/23/2018 10:37 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,303	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,303	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)		22,302	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)		1,834	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)		1,846	15.00
16.00	Nursery days (title V or XIX only)		683	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		38,928,065	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)		38,928,065	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		38,928,065	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,375.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,522,484	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,522,484	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 5/23/2018 10:37 am	
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)	1,654,078	1,846	896.03	683	611,988	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	11,131,300	6,354	1,751.86	508	889,945	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,698,598	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,723,015	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					6,001	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,375.40	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,253,775	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 10:37 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,682,656	38,928,065	0.094602	8,253,775	780,824	90.00
91.00	Nursing School cost	0	38,928,065	0.000000	8,253,775	0	91.00
92.00	Allied health cost	0	38,928,065	0.000000	8,253,775	0	92.00
93.00	All other Medical Education	0	38,928,065	0.000000	8,253,775	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 10:37 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		15,193,774	30.00
31.00	03100	INTENSIVE CARE UNIT		7,501,812	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.265604	3,189,418	50.00
51.00	05100	RECOVERY ROOM	0.121387	595,951	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.017323	477,268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107366	8,126,667	54.00
56.00	05600	RADIOISOTOPE	0.217663	822,683	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.031540	1,490,135	59.00
60.00	06000	LABORATORY	0.147102	8,415,944	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.140605	4,294,276	65.00
66.00	06600	PHYSICAL THERAPY	0.429762	841,080	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285513	454,655	67.00
68.00	06800	SPEECH PATHOLOGY	0.200018	287,581	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135446	1,839,373	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.144770	167,322	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.207496	1,340,899	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.435271	1,451,594	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208075	10,807,880	73.00
74.00	07400	RENAL DIALYSIS	0.361842	1,420,189	74.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.627160	5,904	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.631112	0	90.00
91.00	09100	EMERGENCY	0.204703	4,507,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.626869	1,280,497	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,816,777	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)		51,816,777	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 10:37 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		4,872,854	30.00
31.00	03100	INTENSIVE CARE UNIT		1,014,501	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		792,174	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.265604	425,892	50.00
51.00	05100	RECOVERY ROOM	0.121387	102,985	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.017323	165,159	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.107366	1,273,316	54.00
56.00	05600	RADIOISOTOPE	0.217663	118,574	56.00
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.031540	262,458	59.00
60.00	06000	LABORATORY	0.147102	2,181,458	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
65.00	06500	RESPIRATORY THERAPY	0.140605	511,902	65.00
66.00	06600	PHYSICAL THERAPY	0.429762	78,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285513	42,950	67.00
68.00	06800	SPEECH PATHOLOGY	0.200018	28,495	68.00
69.00	06900	ELECTROCARDIOLOGY	0.135446	254,627	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.144770	26,061	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.207496	157,657	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.435271	90,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.208075	2,217,582	73.00
74.00	07400	RENAL DIALYSIS	0.361842	168,155	74.00
76.00	03140	CARDIOLOGY	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.627160	2,115	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.631112	0	90.00
91.00	09100	EMERGENCY	0.204703	796,862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.626869	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,905,273	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)		8,905,273	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		17,194,818	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)		126,753	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)		186.31	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		10.27	30.00
31.00	Percentage of Medicaid patient days (see instructions)		32.01	31.00
32.00	Sum of lines 30 and 31		42.28	32.00
33.00	Allowable disproportionate share percentage (see instructions)		24.10	33.00
34.00	Disproportionate share adjustment (see instructions)		1,035,988	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000452472	0.000356332	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,704,645	2,411,190	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	2,022,926	607,752	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,630,678		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	20,988,237		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		20,988,237	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,523,986	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)		22,517,402	59.00
60.00	Primary payer payments		7,281	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		22,510,121	61.00
62.00	Deductibles billed to program beneficiaries		1,874,964	62.00
63.00	Coinurance billed to program beneficiaries		54,138	63.00
64.00	Allowable bad debts (see instructions)		1,117,624	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		726,456	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		514,804	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		21,307,475	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)		-15,110	70.93
70.94	HRR adjustment amount (see instructions)		-181,529	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		163,412	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		20,947,424	71.00
71.01	Sequestration adjustment (see instructions)		418,948	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		19,874,811	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)		653,665	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		774,834	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,969	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,106,579	2.00
3.00	OPPS payments		6,577,267	3.00
4.00	Outlier payment (see instructions)		23,934	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.820	5.00
6.00	Line 2 times line 5		7,467,395	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		88.40	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)		5,969	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		27,991	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)		27,991	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		27,991	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		22,022	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		5,969	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)		6,601,201	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,310,149	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		5,297,021	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)		5,297,021	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		5,297,021	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		568,998	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		369,849	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		324,038	36.00
37.00	Subtotal (see instructions)		5,666,870	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,666,870	40.00
40.01	Sequestration adjustment (see instructions)		113,337	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		5,541,004	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		12,529	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0048		Period: From 01/01/2017 To 12/31/2017		Worksheet E-1 Part I Date/Time Prepared: 5/23/2018 10:37 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		19,874,811		5,541,004	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		19,874,811		5,541,004	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		653,665		12,529	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		20,528,476		5,553,533	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/23/2018 10:37 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	8,505	7,110		26.00
27.00	Total Inpatient Days (see instructions)	29,188	29,188		27.00
28.00	Ratio of inpatient days to total inpatient days	0.291387	0.243593		28.00
29.00	Program direct GME amount	0	0		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		0		30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/23/2018 10:37 am
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		4,012,779	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		23,867,587	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		7,281	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		23,860,306	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		9,112,548	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		9,112,548	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		32,972,854	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.723635	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.276365	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		0	50.00

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

Provider CCN: 14-0048

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

Worksheet G

Date/Time Prepared:
5/23/2018 10:37 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	229,643,000	0	0	0	1.00
2.00	Temporary investments	82,664,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	672,820,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	191,459,000	0	0	0	9.00
10.00	Due from other funds	23,729,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,200,315,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	158,161,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,982,049,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,494,843,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,508,470,000	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)	2,126,583,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,829,122,000	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	444,752,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,273,874,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,600,772,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	346,603,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	386,896,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	88,828,000	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	421,544,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,243,871,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	1,493,648,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	848,770,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,342,418,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,586,289,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,014,483,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,014,483,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,600,772,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0048

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

Worksheet G-1

Date/Time Prepared:
5/23/2018 10:37 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		5,025,901,225		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-11,418,225			2.00
3.00	Total (sum of line 1 and line 2)		5,014,483,000		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		5,014,483,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,014,483,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0048

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/23/2018 10:37 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	65,414,712		65,414,712	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	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)	65,414,712		65,414,712	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	23,936,216		23,936,216	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	23,936,216		23,936,216	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	89,350,928		89,350,928	17.00
18.00	Ancillary services	159,741,548	165,444,509	325,186,057	18.00
19.00	Outpatient services	19,289,653	70,021,982	89,311,635	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	1,791,710	0	1,791,710	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	270,173,839	235,466,491	505,640,330	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		155,824,388		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)		155,824,388		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0048

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

Worksheet G-3

Date/Time Prepared:
5/23/2018 10:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	505,640,330	1.00
2.00	Less contractual allowances and discounts on patients' accounts	362,112,070	2.00
3.00	Net patient revenues (line 1 minus line 2)	143,528,260	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	155,824,388	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,296,128	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY/ MISC INCOME	1,016,093	24.00
25.00	Total other income (sum of lines 6-24)	1,016,093	25.00
26.00	Total (line 5 plus line 25)	-11,280,035	26.00
27.00	NET NON OPERATING INCOME	138,190	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	138,190	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-11,418,225	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet I-5 Date/Time Prepared: 5/23/2018 10:37 am
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		1.00	2.00	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B				
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	0	0	2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	0	0	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	0		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. 1-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0048	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/23/2018 10:37 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,393,283	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,143	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)		79.97	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)		10.27	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		32.01	8.00
9.00	Sum of lines 7 and 8		42.28	9.00
10.00	Allowable disproportionate share percentage (see instructions)		8.94	10.00
11.00	Disproportionate share adjustment (see instructions)		124,560	11.00
12.00	Total prospective capital payments (see instructions)		1,523,986	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00