

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: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 11:22 am
--	-----------------------	---	---

PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for Full or "L" for Low.

Contractor use only
 5. Cost Report Status
 (1) As Submitted
 (2) Settled without Audit
 (3) Settled with Audit
 (4) Reopened
 (5) Amended

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 2/26/2018 Time: 11:22 am

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 OTTAWA REGIONAL HOSPITAL & HEALTHCARE (14-0110) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-7,084	4,444	0	0	1.00
2.00 Subprovider - IPF	0	19	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00 Total	0	-7,065	4,444	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: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:20 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 1100 EAST NORRIS DRIVE			PO Box:							1.00	
2.00	City: OTTAWA			State: IL		Zip Code: 61350		County: LA SALLE			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00		3.00	4.00	5.00	6.00	7.00	8.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		OTTAWA REGIONAL HOSPITAL & HEALTHCARE		140110	99914	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF		OTTAWA REGIONAL PSYCHIATRIC UNIT		14S110	16974	4	05/01/1984	N	P	0	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
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)						10/01/2016	09/30/2017		20.00		
21.00	Type of Control (see instructions)						2			21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							1		N	23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	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.			1,352	807	0	0	2,893	107		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:20 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.		2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1	10/01/2013		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		Y	Y		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N		40.00
		V	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		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 Criteria 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)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:20 am		
	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						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)						62.01	0.00
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
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	0.000000
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
		1.00	2.00	3.00	4.00	5.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:20 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.			Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0	71.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:20 am	
			1.00	2.00	3.00
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
			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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N	87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:20 am		
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N		110.00	
					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.				Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.				2			118.00
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	120,000		0		0		118.01
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
DO NOT USE THIS LINE								
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	Y		119.00 120.00
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								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 11:20 am	
		1.00		2.00			
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		149006		140.00	
		1.00		2.00		3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131		141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:				142.00	
143.00	City: PEORIA	State: IL		Zip Code: 61603		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y				144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N				149.00	
		Part A 1.00		Part B 2.00		Title V 3.00	
						Title XIX 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N				165.00	
		Name 0		County 1.00		State 2.00	
						Zip Code 3.00	
						CBSA 4.00	
						FTE/Campus 5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y				167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0				168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99				169.00	
				Beginning 1.00		Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016		09/30/2017		170.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0110	Period:	Worksheet S-2
		From 10/01/2016	Part I
		To 09/30/2017	Date/Time Prepared: 2/26/2018 11:20 am
		1.00	2.00
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 11:20 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	12/14/2017	Y	12/14/2017
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			N		N	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		Y	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 11:20 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

		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.	DIRECTOR	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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	82	29,930	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)		82	29,930	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		87	31,755	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	8	2,920		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		95				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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,001	1,153	10,716			1.00
2.00 HMO and other (see instructions)	605	3,700				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,001	1,153	10,716			7.00
8.00 INTENSIVE CARE UNIT	563	98	899			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		101	932			13.00
14.00 Total (see instructions)	4,564	1,352	12,547	0.00	599.56	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,198	0	2,141	0.00	9.10	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	608.66	27.00
28.00 Observation Bed Days		436	2,255			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	107	153			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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2018 11:20 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	1,291	407	3,543	1.00
2.00 HMO and other (see instructions)				177	1,058		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		1,291	407	3,543	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		178	0	193	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
2/26/2018 11:20 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	38,654,995	0	38,654,995	1,189,447.00	32.50
2.00	Non-physician anesthetist Part A		317,686	0	317,686	1,553.00	204.56
3.00	Non-physician anesthetist Part B		1,281,391	0	1,281,391	5,653.00	226.67
4.00	Physician-Part A - Administrative		268,550	0	268,550	1,230.00	218.33
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		2,864,283	0	2,864,283	13,255.00	216.09
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		503,558	18,363	521,921	19,702.00	26.49
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,894,181	0	1,894,181	27,851.00	68.01
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		168,300	0	168,300	2,480.00	67.86
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,200,812	0	7,200,812	202,094.00	35.63
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,984,739	0	8,984,739		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		146,804	0	146,804		
20.00	Non-physician anesthetist Part A		39,493	0	39,493		
21.00	Non-physician anesthetist Part B		156,377	0	156,377		
22.00	Physician Part A - Administrative		21,964	0	21,964		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		234,912	0	234,912		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		2,330,787	0	2,330,787		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
2/26/2018 11:20 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	
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	54,987	0	54,987	2,008.00	27.38 26.00
27.00	Administrative & General	5.00	2,382,807	0	2,382,807	88,344.00	26.97 27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00 28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00 29.00
30.00	Operation of Plant	7.00	1,124,557	0	1,124,557	42,051.00	26.74 30.00
31.00	Laundry & Linen Service	8.00	36,053	0	36,053	2,425.00	14.87 31.00
32.00	Housekeeping	9.00	993,426	0	993,426	75,115.00	13.23 32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00 33.00
34.00	Dietary	10.00	753,176	0	753,176	46,024.00	16.36 34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00 35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	801,523	0	801,523	22,355.00	35.85 38.00
39.00	Central Services and Supply	14.00	52,461	0	52,461	4,189.00	12.52 39.00
40.00	Pharmacy	15.00	789,939	0	789,939	21,115.00	37.41 40.00
41.00	Medical Records & Medical Records Library	16.00	1,269,079	0	1,269,079	48,288.00	26.28 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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet S-3
Part III
Date/Time Prepared:
2/26/2018 11:20 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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)	34,191,635	0	34,191,635	1,168,986.00	29.25	1.00
2.00	Excluded area salaries (see instructions)	503,558	18,363	521,921	19,702.00	26.49	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,688,077	-18,363	33,669,714	1,149,284.00	29.30	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,263,293	0	9,263,293	232,425.00	39.85	4.00
5.00	Subtotal wage-related costs (see inst.)	11,337,490	0	11,337,490	0.00	33.67	5.00
6.00	Total (sum of lines 3 thru 5)	54,288,860	-18,363	54,270,497	1,381,709.00	39.28	6.00
7.00	Total overhead cost (see instructions)	8,258,008	0	8,258,008	351,914.00	23.47	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2018 11:20 am
-----------------------------	-----------------------	---	---

			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,586,991	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		5,420,225	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	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)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		133,024	16.00
TAXES				
17.00	FICA-Employers Portion Only		2,315,800	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	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))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		128,248	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		9,584,288	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: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet S-3 Part V Date/Time Prepared: 2/26/2018 11:20 am
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		1,894,181	9,584,288
2.00	Hospital		1,894,181	9,584,288
3.00	Subprovider - IPF		0	0
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF		0	0
9.00	Hospital-Based NF		0	0
10.00	Hospital-Based OLTC		0	0
11.00	Hospital-Based HHA		0	0
12.00	Separately Certified ASC		0	0
13.00	Hospital-Based Hospice		0	0
14.00	Hospital-Based Health Clinic RHC		0	0
15.00	Hospital-Based Health Clinic FQHC		0	0
16.00	Hospital-Based-CMHC		0	0
17.00	Renal Dialysis		0	0
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet S-10 Date/Time Prepared: 2/26/2018 11:20 am
---	--	-----------------------	---	---

				1.00		
Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.234142	1.00	
Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			12,776,571	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			82,155,102	6.00	
7.00	Medicaid cost (line 1 times line 6)			19,235,960	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			6,459,389	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)						
9.00	Net revenue from stand-alone CHIP			0	9.00	
10.00	Stand-alone CHIP charges			0	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00	
Other state or local government indigent care program (see instructions for each line)						
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)						
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			6,459,389	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)	6,029,162	487,104	6,516,266	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,411,680	487,104	1,898,784	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	90,678	64,149	154,827	22.00	
23.00	Cost of charity care (line 21 minus line 22)	1,321,002	422,955	1,743,957	23.00	
				1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)			5,378,501	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			325,697	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			501,071	27.01	
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			4,877,430	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,317,385	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,061,342	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,520,731	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		468,140	468,140	75,168	543,308	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,023,624	3,023,624	30,912	3,054,536	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	54,987	11,872,638	11,927,625	0	11,927,625	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,382,807	17,348,031	19,730,838	-911,356	18,819,482	5.00
7.00	00700	OPERATION OF PLANT	1,124,557	2,723,583	3,848,140	913,331	4,761,471	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,053	356,358	392,411	0	392,411	8.00
9.00	00900	HOUSEKEEPING	993,426	187,510	1,180,936	0	1,180,936	9.00
10.00	01000	DIETARY	753,176	626,810	1,379,986	0	1,379,986	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	801,523	85,811	887,334	0	887,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,461	122,445	174,906	-177,571	-2,665	14.00
15.00	01500	PHARMACY	789,939	3,863,827	4,653,766	-3,184,448	1,469,318	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,269,079	77,853	1,346,932	0	1,346,932	16.00
17.00	01700	SOCIAL SERVICE	0	91	91	-91	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	295,009	295,009	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,244,624	2,749,807	8,994,431	-2,019,833	6,974,598	30.00
31.00	03100	INTENSIVE CARE UNIT	796,767	250,889	1,047,656	0	1,047,656	31.00
40.00	04000	SUBPROVIDER - IPF	476,651	4,367	481,018	18,363	499,381	40.00
43.00	04300	NURSERY	0	0	0	308,543	308,543	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,031,489	3,578,309	4,609,798	-1,911,563	2,698,235	50.00
51.00	05100	RECOVERY ROOM	719,513	28,765	748,278	0	748,278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,358,927	1,358,927	52.00
53.00	05300	ANESTHESIOLOGY	1,902,381	788,024	2,690,405	-295,009	2,395,396	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,647,063	2,527,279	6,174,342	-28,509	6,145,833	54.00
58.00	05800	MRI	7,009	153,988	160,997	17,245	178,242	58.00
60.00	06000	LABORATORY	1,899,361	2,283,431	4,182,792	0	4,182,792	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	752,310	453,081	1,205,391	-134,308	1,071,083	65.00
66.00	06600	PHYSICAL THERAPY	2,366,819	651,142	3,017,961	-253,215	2,764,746	66.00
67.00	06700	OCCUPATIONAL THERAPY	677,650	269,877	947,527	-10,872	936,655	67.00
68.00	06800	SPEECH PATHOLOGY	138,061	3,378	141,439	0	141,439	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	158,333	158,333	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,043	4,043	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,250,046	2,250,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,224,908	1,224,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,180,219	3,180,219	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,658,126	882,247	2,540,373	-978,514	1,561,859	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,309,509	72,548	2,382,057	-90,008	2,292,049	76.01
76.02	03610	SLEEP LAB	113,848	19,245	133,093	0	133,093	76.02
76.97	07697	CARDIAC REHABILITATION	89,899	241	90,140	455,386	545,526	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	5,539,000	3,789,975	9,328,975	-182,106	9,146,869	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,628,088	59,263,314	97,891,402	113,030	98,004,432	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,907	43,835	70,742	0	70,742	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	882,027	882,027	-113,030	768,997	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	77,331	77,331	0	77,331	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	38,654,995	60,266,507	98,921,502	0	98,921,502	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,370,642	2,913,950	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,054,536	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,202	11,919,423	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-389,572	18,429,910	5.00
7.00	00700	OPERATION OF PLANT	0	4,761,471	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	392,411	8.00
9.00	00900	HOUSEKEEPING	0	1,180,936	9.00
10.00	01000	DIETARY	-418,493	961,493	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	887,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-2,665	14.00
15.00	01500	PHARMACY	0	1,469,318	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,411	1,344,521	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-295,009	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,857,102	5,117,496	30.00
31.00	03100	INTENSIVE CARE UNIT	-131,928	915,728	31.00
40.00	04000	SUBPROVIDER - IPF	0	499,381	40.00
43.00	04300	NURSERY	0	308,543	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	2,698,235	50.00
51.00	05100	RECOVERY ROOM	0	748,278	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,358,927	52.00
53.00	05300	ANESTHESIOLOGY	-2,282,395	113,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-835,640	5,310,193	54.00
58.00	05800	MRI	0	178,242	58.00
60.00	06000	LABORATORY	-28,021	4,154,771	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,071,083	65.00
66.00	06600	PHYSICAL THERAPY	-188,440	2,576,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	-37,145	899,510	67.00
68.00	06800	SPEECH PATHOLOGY	0	141,439	68.00
69.00	06900	ELECTROCARDIOLOGY	0	158,333	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,043	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,250,046	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,224,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,180,219	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,561,859	75.00
76.00	03160	STRESS TESTING	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-1,624,149	667,900	76.01
76.02	03610	SLEEP LAB	0	133,093	76.02
76.97	07697	CARDIAC REHABILITATION	0	545,526	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-4,878,034	4,268,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
117.00	06950	HOMEMAKER	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,605,899	87,398,533	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	70,742	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	768,997	192.00
194.00	07950	CARDINAL SLEEP	0	0	194.00
194.01	07951	OTHER NRCC	0	77,331	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,605,899	88,315,603	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,586	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	30,912	2.00
	O		0	82,498	
B - DELIVERY ROOM AND NURSERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,101,419	512,877	1.00
2.00	NURSERY	43.00	210,516	98,027	2.00
	O		1,311,935	610,904	
C - EKG HOLTER, STRESS, EEG					
1.00	ELECTROCARDIOLOGY	69.00	158,333	0	1.00
2.00	CARDIAC REHABILITATION	76.97	141,833	313,553	2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00	4,043	0	3.00
	O		304,209	313,553	
D - SOCIAL SERVICES RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	91	1.00
	TOTALS		0	91	
I - C-SECTION					
1.00	OPERATING ROOM	50.00	174,236	81,133	1.00
	O		174,236	81,133	
K - NONPHYSICIAN ANESTHETISTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	4,421	290,588	1.00
	O		4,421	290,588	
M - MOB HOSPITAL STORAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,399	1.00
	O		0	24,399	
O - PSYCH ADMIN					
1.00	ADULTS & PEDIATRICS	30.00	71,645	0	1.00
2.00	SUBPROVIDER - IPF	40.00	18,363	0	2.00
	O		90,008	0	
V - MERCURY CIRCLE BUILDING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,096	1.00
2.00	OPERATION OF PLANT	7.00	0	81,134	2.00
	O		0	84,230	
W - RADIOLOGY SPACE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,401	1.00
	O		0	4,401	
AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,250,046	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,224,908	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,180,219	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
	O		0	6,655,173	
AD - MRI SALARIES					
1.00	MRI	58.00	9,822	7,423	1.00
	O		9,822	7,423	
AE - STREATOR EXPENSES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	23,582	1.00
2.00	OPERATION OF PLANT	7.00	0	832,197	2.00
	O		0	855,779	
500.00	Grand Total: Increases		1,894,631	9,010,172	500.00

RECLASSIFICATIONS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-6
Date/Time Prepared:
2/26/2018 11:20 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	82,498	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	82,498			
B - DELIVERY ROOM AND NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	1,311,935	610,904	0		1.00
2.00		0.00	0	0	0		2.00
	0		1,311,935	610,904			
C - EKG HOLTER, STRESS, EEG							
1.00	ASC (NON-DISTINCT PART)	75.00	304,209	313,553	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		304,209	313,553			
D - SOCIAL SERVICES RECLASS							
1.00	SOCIAL SERVICE	17.00	0	91	0		1.00
	TOTALS		0	91			
I - C-SECTION							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	174,236	81,133	0		1.00
	0		174,236	81,133			
K - NONPHYSICIAN ANESTHETISTS							
1.00	ANESTHESIOLOGY	53.00	4,421	290,588	0		1.00
	0		4,421	290,588			
M - MOB HOSPITAL STORAGE							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	24,399	0		1.00
	0		0	24,399			
O - PSYCH ADMIN							
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	90,008	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		90,008	0			
V - MERCURY CIRCLE BUILDING							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	84,230	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	84,230			
W - RADIOLOGY SPACE							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,401	0		1.00
	0		0	4,401			
AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	142,150	0		1.00
2.00	PHARMACY	15.00	0	36,725	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	168,639	0		3.00
4.00	OPERATING ROOM	50.00	0	1,103,165	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	134,308	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	160,990	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	10,872	0		7.00
8.00	ASC (NON-DISTINCT PART)	75.00	0	311,091	0		8.00
9.00	EMERGENCY	91.00	0	182,106	0		9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	0	665	0		10.00
11.00	PHARMACY	15.00	0	2,925	0		11.00
12.00	OPERATING ROOM	50.00	0	1,063,767	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,665	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	92,225	0		14.00
15.00	ASC (NON-DISTINCT PART)	75.00	0	49,661	0		15.00
16.00	CENTRAL SERVICES & SUPPLY	14.00	0	35,421	0		16.00
17.00	PHARMACY	15.00	0	3,144,798	0		17.00
	0		0	6,655,173			
AD - MRI SALARIES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	9,822	7,423	0		1.00
	0		9,822	7,423			
AE - STREATOR EXPENSES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	855,779	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	855,779			
500.00	Grand Total: Decreases		1,894,631	9,010,172			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-7
Part I
Date/Time Prepared:
2/26/2018 11:20 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,227,906	0	0	0	1.00
2.00	Land Improvements	2,924,219	63,421	0	63,421	2.00
3.00	Buildings and Fixtures	82,638,941	161,078	0	161,078	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	45,172,943	3,212,882	0	3,212,882	6.00
7.00	HIT designated Assets	-8,270,599	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	125,693,410	3,437,381	0	3,437,381	8.00
9.00	Reconciling Items	2,278,153	0	0	0	2,278,153
10.00	Total (line 8 minus line 9)	123,415,257	3,437,381	0	3,437,381	-2,278,153
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,227,906	0			1.00
2.00	Land Improvements	2,987,640	0			2.00
3.00	Buildings and Fixtures	82,800,019	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	48,385,825	0			6.00
7.00	HIT designated Assets	-8,270,599	0			7.00
8.00	Subtotal (sum of lines 1-7)	129,130,791	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	129,130,791	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-7
Part II
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	416,554	0	0	51,586	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,992,712	0	0	30,912	0	2.00
3.00	Total (sum of lines 1-2)	3,409,266	0	0	82,498	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	468,140	1.00			
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,023,624	2.00			
3.00	Total (sum of lines 1-2)	0	3,491,764	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-7
Part III
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	80,744,966	0	80,744,966	0.625296	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,385,825	0	48,385,825	0.374704	0	2.00
3.00	Total (sum of lines 1-2)	129,130,791	0	129,130,791	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,888,306	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,992,712	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,881,018	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-77,528	103,172	0	0	2,913,950	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	61,824	0	0	3,054,536	2.00
3.00	Total (sum of lines 1-2)	-77,528	164,996	0	0	5,968,486	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8

Date/Time Prepared:
2/26/2018 11:20 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.	
			3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-29,813	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-11,244,116			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	2,556,392			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-418,493	DIETARY	10.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-2,411	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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 - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist	A	-295,009	NONPHYSICIAN ANESTHETISTS	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8

Date/Time Prepared:
2/26/2018 11:20 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	3.00	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 AMORTIZED CAPITALIZED INTEREST	A	-27,171		CAP REL COSTS-BLDG & FIXT	1.00	11 33.00
33.01 PHYSICIAN RECRUITING EXPENSE	A	-3,581		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.01
33.02 PHYSICIAN RECRUITING EXPENSE	A	-20,723		ADMINISTRATIVE & GENERAL	5.00	0 33.02
33.03 PHYSICIAN RECRUITING EXPENSE	A	-4,621		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.03
33.04 TRUSTEE FEES	A	18,814		ADMINISTRATIVE & GENERAL	5.00	0 33.04
33.05 ADMINISTRATION ALCOHOL	A	-62		ADMINISTRATIVE & GENERAL	5.00	0 33.05
33.06 DUES & SUBSCRIPTIONS	A	-5,400		ADMINISTRATIVE & GENERAL	5.00	0 33.06
33.07 ADVERTISING	A	-2,109		ADMINISTRATIVE & GENERAL	5.00	0 33.07
33.08 AHA LOBBYING FEES	A	-3,227		ADMINISTRATIVE & GENERAL	5.00	0 33.08
33.09 IHA LOBBYING FEES	A	-27,271		ADMINISTRATIVE & GENERAL	5.00	0 33.09
33.10 PATIENT TRANSPORTATION	A	-12,124		ADMINISTRATIVE & GENERAL	5.00	0 33.10
33.11 ROTARY FEES	A	-200		ADMINISTRATIVE & GENERAL	5.00	0 33.11
33.12 MEDICAID TAX ASSESSMENT - APPEAL	A	-2,860,706		ADMINISTRATIVE & GENERAL	5.00	0 33.12
33.13 COMMUNITY EDUCATION REVENUE	B	-17,113		ADMINISTRATIVE & GENERAL	5.00	0 33.13
33.14 MISCELLANEOUS REVENUE	B	-111,481		ADMINISTRATIVE & GENERAL	5.00	0 33.14
33.15 MISCELLANEOUS REVENUE	B	-6,477		ADMINISTRATIVE & GENERAL	5.00	0 33.15
33.16 MISCELLANEOUS REVENUE	B	-151,976		PHYSICAL THERAPY	66.00	0 33.16
33.17 INTEREST/INVESTMENT INCOME OFFSET	B	-50,357		CAP REL COSTS-BLDG & FIXT	1.00	11 33.17
33.18 CLINICAL LAB OTHER REVENUE	B	-28,021		LABORATORY	60.00	0 33.18
33.19 ASSET REDUCTION ADD-BACK	A	2,448,170		CAP REL COSTS-BLDG & FIXT	1.00	9 33.19
33.20 MOONLIGHTING RESIDENTS	B	-208,542		EMERGENCY	91.00	0 33.20
33.21 MOONLIGHTING RESIDENTS	B	-61,126		EMERGENCY	91.00	0 33.21
33.22 MISCELLANEOUS REVENUE	B	-37,145		OCCUPATIONAL THERAPY	67.00	0 33.22
33.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10,605,899				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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8-1

Date/Time Prepared:
2/26/2018 11:20 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	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATIONS	0	13,442,032	1.00
2.00	31.00	INTENSIVE CARE UNIT	EICU	0	131,928	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	NONCAPITAL EXPENSE	5,274,768	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	NEW BLDG EXPENSE	279,479	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NEW MME EXPENSE	1,688,945	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NONCAPITAL EXPENSE	8,887,160	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,130,352	13,573,960	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	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	B	0.00	OSF 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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8-1

Date/Time Prepared:
2/26/2018 11:20 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	-13,442,032	0		1.00
2.00	-131,928	0		2.00
3.00	5,274,768	0		3.00
4.00	279,479	0		4.00
4.01	1,688,945	0		4.01
4.02	8,887,160	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	2,556,392			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet A-8-2
Date/Time Prepared:
2/26/2018 11:20 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	1,857,102	1,857,102	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	2,461,139	2,143,453	317,686	239,400	1,553	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	835,640	835,640	0	0	0	3.00
4.00	60.00	LABORATORY	117,600	0	117,600	260,300	2,340	4.00
5.00	66.00	PHYSICAL THERAPY	50,700	0	50,700	211,500	140	5.00
6.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,636,352	1,610,065	26,287	181,300	140	6.00
7.00	91.00	EMERGENCY	4,719,200	4,476,937	242,263	211,500	1,090	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			11,677,733	10,923,197	754,536		5,263	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	53.00	ANESTHESIOLOGY	178,744	8,937	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	292,838	14,642	0	0	0	4.00
5.00	66.00	PHYSICAL THERAPY	14,236	712	0	0	0	5.00
6.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	12,203	610	0	0	0	6.00
7.00	91.00	EMERGENCY	110,834	5,542	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			608,855	30,443	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	1,857,102		1.00
2.00	53.00	ANESTHESIOLOGY	0	178,744	138,942	2,282,395		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	835,640		3.00
4.00	60.00	LABORATORY	0	292,838	0	0		4.00
5.00	66.00	PHYSICAL THERAPY	0	14,236	36,464	36,464		5.00
6.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	12,203	14,084	1,624,149		6.00
7.00	91.00	EMERGENCY	0	110,834	131,429	4,608,366		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	608,855	320,919	11,244,116		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		BLDG & FIXT	MVBLE EQUIP				
	0	1.00	2.00	4.00	4A		
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT	2,913,950	2,913,950				1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP	3,054,536		3,054,536			2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11,919,423	25,891	612	11,945,926		4.00	
5.00 00500 ADMINISTRATIVE & GENERAL	18,429,910	275,146	145,301	895,472	19,745,829	5.00	
7.00 00700 OPERATION OF PLANT	4,761,471	918,819	5,136	348,067	6,033,493	7.00	
8.00 00800 LAUNDRY & LINEN SERVICE	392,411	11,543	0	11,159	415,113	8.00	
9.00 00900 HOUSEKEEPING	1,180,936	17,425	7,745	307,480	1,513,586	9.00	
10.00 01000 DIETARY	961,493	97,388	41,356	233,119	1,333,356	10.00	
11.00 01100 CAFETERIA	0	0	0	0	0	11.00	
13.00 01300 NURSING ADMINISTRATION	887,334	25,719	96,586	248,083	1,257,722	13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY	-2,665	57,518	225,654	16,237	296,744	14.00	
15.00 01500 PHARMACY	1,469,318	14,890	43,629	244,498	1,772,335	15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	1,344,521	47,993	2,186	392,799	1,787,499	16.00	
17.00 01700 SOCIAL SERVICE	0	8,602	0	0	8,602	17.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00	
23.00 02300 PARAMED PRGM-(SPECIFY)	0	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	5,117,496	222,342	235,556	1,548,916	7,124,310	30.00	
31.00 03100 INTENSIVE CARE UNIT	915,728	23,590	26,143	246,611	1,212,072	31.00	
40.00 04000 SUBPROVIDER - IPF	499,381	88,811	70	153,214	741,476	40.00	
43.00 04300 NURSERY	308,543	0	0	65,158	373,701	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	2,698,235	84,910	546,563	373,190	3,702,898	50.00	
51.00 05100 RECOVERY ROOM	748,278	9,106	0	222,700	980,084	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1,358,927	0	0	286,977	1,645,904	52.00	
53.00 05300 ANESTHESIOLOGY	113,001	0	56,108	587,447	756,556	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	5,310,193	186,421	632,513	1,125,781	7,254,908	54.00	
58.00 05800 MRI	178,242	25,842	0	5,209	209,293	58.00	
60.00 06000 LABORATORY	4,154,771	143,769	134,655	587,881	5,021,076	60.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	1,071,083	22,692	34,496	232,851	1,361,122	65.00	
66.00 06600 PHYSICAL THERAPY	2,576,306	215,463	83,253	732,566	3,607,588	66.00	
67.00 06700 OCCUPATIONAL THERAPY	899,510	30,728	0	51,785	982,023	67.00	
68.00 06800 SPEECH PATHOLOGY	141,439	5,882	0	42,732	190,053	68.00	
69.00 06900 ELECTROCARDIOLOGY	158,333	0	0	49,006	207,339	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	4,043	0	0	1,251	5,294	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,250,046	0	0	0	2,250,046	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1,224,908	0	0	0	1,224,908	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	3,180,219	0	0	0	3,180,219	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	1,561,859	132,448	215,004	419,058	2,328,369	75.00	
76.00 03160 STRESS TESTING	0	0	0	0	0	76.00	
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	667,900	36,659	74,249	686,969	1,465,777	76.01	
76.02 03610 SLEEP LAB	133,093	0	43,612	35,238	211,943	76.02	
76.97 07697 CARDIAC REHABILITATION	545,526	0	0	71,725	617,251	76.97	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	4,268,835	174,681	31,941	1,714,419	6,189,876	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00	
116.00 11600 HOSPICE	0	0	0	0	0	116.00	
117.00 06950 HOMEMAKER	0	0	0	0	0	117.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	87,398,533	2,904,278	2,682,368	11,937,598	87,008,365	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	70,742	9,672	0	8,328	88,742	190.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	768,997	0	372,168	0	1,141,165	192.00	
194.00 07950 CARDINAL SLEEP	0	0	0	0	0	194.00	
194.01 07951 OTHER NRCC	77,331	0	0	0	77,331	194.01	
200.00	Cross Foot Adjustments	0	0	0	0	200.00	
201.00	Negative Cost Centers	0	0	0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	88,315,603	2,913,950	3,054,536	11,945,926	88,315,603	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	19,745,829				5.00	
7.00	00700	OPERATION OF PLANT	1,737,447	7,770,940			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	119,539	52,948	587,600		8.00	
9.00	00900	HOUSEKEEPING	435,863	79,930	0	2,029,379	9.00	
10.00	01000	DIETARY	383,963	446,728	0	118,697	10.00	
11.00	01100	CAFETERIA	0	0	0	1,691,976	11.00	
13.00	01300	NURSING ADMINISTRATION	362,182	117,976	0	31,345	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	85,452	263,837	0	70,088	14.00	
15.00	01500	PHARMACY	510,374	68,302	0	18,161	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	514,741	220,146	0	58,474	16.00	
17.00	01700	SOCIAL SERVICE	2,477	39,457	0	10,493	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
23.00	02300	PARAMED ED PRGM - (SPECIFY)	0	0	0	0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,051,566	1,019,900	224,898	270,981	457,932	30.00
31.00	03100	INTENSIVE CARE UNIT	349,037	108,210	20,674	28,744	23,049	31.00
40.00	04000	SUBPROVIDER - IPF	213,521	407,384	4,969	108,249	109,787	40.00
43.00	04300	NURSERY	107,614	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,066,312	389,490	25,233	103,496	0	50.00
51.00	05100	RECOVERY ROOM	282,232	41,771	0	11,076	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	473,966	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	217,863	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,089,172	855,127	29,291	227,215	0	54.00
58.00	05800	MRI	60,269	118,540	0	31,479	0	58.00
60.00	06000	LABORATORY	1,445,904	659,479	0	175,199	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	391,958	104,090	0	27,668	0	65.00
66.00	06600	PHYSICAL THERAPY	1,038,866	988,344	60,569	262,596	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	282,790	140,950	0	37,443	0	67.00
68.00	06800	SPEECH PATHOLOGY	54,729	26,982	0	7,175	0	68.00
69.00	06900	ELECTROCARDIOLOGY	59,707	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,524	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	647,939	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	352,733	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	915,798	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	670,493	607,547	102,736	161,432	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	422,095	168,158	0	44,663	0	76.01
76.02	03610	SLEEP LAB	61,033	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	177,748	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,782,480	801,276	119,230	212,911	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,369,387	7,726,572	587,600	2,017,585	2,282,744	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,555	44,368	0	11,794	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	328,618	0	0	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	22,269	0	0	0	0	194.01
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)	19,745,829	7,770,940	587,600	2,029,379	2,282,744	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
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	1,691,976					11.00
13.00	01300	37,289	1,806,514				13.00
14.00	01400	7,011	0	723,132			14.00
15.00	01500	35,440	0	1,733	2,406,345		15.00
16.00	01600	84,867	168,382	1,483	0	2,835,592	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	328,865	652,467	14,653	0	141,780	30.00
31.00	03100	40,184	79,702	4,325	0	28,356	31.00
40.00	04000	32,091	63,658	420	0	28,356	40.00
43.00	04300	10,848	21,508	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	80,019	158,779	15,579	0	198,491	50.00
51.00	05100	34,742	68,932	3,036	0	28,356	51.00
52.00	05200	47,753	94,735	0	0	56,712	52.00
53.00	05300	20,580	0	12,109	0	85,068	53.00
54.00	05400	209,919	0	108,469	0	680,539	54.00
58.00	05800	1,430	0	446	0	85,068	58.00
60.00	06000	149,015	0	33,218	0	453,695	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	46,114	0	0	0	28,356	65.00
66.00	06600	140,539	0	2,643	0	113,424	66.00
67.00	06700	29,301	0	0	0	28,356	67.00
68.00	06800	6,418	0	156	0	0	68.00
69.00	06900	9,139	0	0	0	28,356	69.00
70.00	07000	244	0	0	0	28,356	70.00
71.00	07100	0	0	322,031	0	141,780	71.00
72.00	07200	0	0	176,100	0	56,712	72.00
73.00	07300	0	0	0	2,406,345	170,136	73.00
75.00	07500	78,065	154,873	15,172	0	113,424	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	59,927	0	939	0	28,356	76.01
76.02	03610	10,465	0	1,820	0	0	76.02
76.97	07697	12,802	0	0	0	56,712	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	173,118	343,478	8,127	0	255,203	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		1,686,185	1,806,514	722,459	2,406,345	2,835,592	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	2,163	0	257	0	0	190.00
192.00	19200	3,628	0	416	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,691,976	1,806,514	723,132	2,406,345	2,835,592	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		17.00	19.00	23.00	24.00	25.00	
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						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	61,029					17.00
19.00	01900	0	0				19.00
23.00	02300	0		0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,051	0	0	12,290,403	0	30.00
31.00	03100	610	0	0	1,894,963	0	31.00
40.00	04000	610	0	0	1,710,521	0	40.00
43.00	04300	0	0	0	513,671	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,272	0	0	5,744,569	0	50.00
51.00	05100	610	0	0	1,450,839	0	51.00
52.00	05200	1,221	0	0	2,320,291	0	52.00
53.00	05300	1,831	0	0	1,094,007	0	53.00
54.00	05400	14,648	0	0	11,469,288	0	54.00
58.00	05800	1,831	0	0	508,356	0	58.00
60.00	06000	9,765	0	0	7,947,351	0	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	610	0	0	1,959,918	0	65.00
66.00	06600	2,441	0	0	6,217,010	0	66.00
67.00	06700	610	0	0	1,501,473	0	67.00
68.00	06800	0	0	0	285,513	0	68.00
69.00	06900	610	0	0	305,151	0	69.00
70.00	07000	610	0	0	36,028	0	70.00
71.00	07100	3,051	0	0	3,364,847	0	71.00
72.00	07200	1,221	0	0	1,811,674	0	72.00
73.00	07300	3,662	0	0	6,676,160	0	73.00
75.00	07500	2,441	0	0	4,234,552	0	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	610	0	0	2,190,525	0	76.01
76.02	03610	0	0	0	285,261	0	76.02
76.97	07697	1,221	0	0	865,734	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	5,493	0	0	9,891,192	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0		0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		61,029	0	0	86,569,297	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	172,879	0	190.00
192.00	19200	0	0	0	1,473,827	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	99,600	0	194.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		61,029	0	0	88,315,603	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet B
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03160	STRESS TESTING	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
76.02	03610	SLEEP LAB	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
117.00	06950	HOMEMAKER	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	CARDINAL SLEEP	194.00
194.01	07951	OTHER NRCC	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet B Part II Date/Time Prepared: 2/26/2018 11:20 am
-------------------------------------	--	-----------------------	---	---

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	25,891	612	26,503	26,503 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	275,146	145,301	420,447	1,988 5.00
7.00 00700	OPERATION OF PLANT	0	918,819	5,136	923,955	773 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	11,543	0	11,543	25 8.00
9.00 00900	HOUSEKEEPING	0	17,425	7,745	25,170	682 9.00
10.00 01000	DIETARY	0	97,388	41,356	138,744	517 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	25,719	96,586	122,305	551 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	57,518	225,654	283,172	36 14.00
15.00 01500	PHARMACY	0	14,890	43,629	58,519	543 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	47,993	2,186	50,179	872 16.00
17.00 01700	SOCIAL SERVICE	0	8,602	0	8,602	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	222,342	235,556	457,898	3,438 30.00
31.00 03100	INTENSIVE CARE UNIT	0	23,590	26,143	49,733	547 31.00
40.00 04000	SUBPROVIDER - IPF	0	88,811	70	88,881	340 40.00
43.00 04300	NURSERY	0	0	0	0	145 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	84,910	546,563	631,473	828 50.00
51.00 05100	RECOVERY ROOM	0	9,106	0	9,106	494 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	637 52.00
53.00 05300	ANESTHESIOLOGY	0	0	56,108	56,108	1,304 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	186,421	632,513	818,934	2,499 54.00
58.00 05800	MRI	0	25,842	0	25,842	12 58.00
60.00 06000	LABORATORY	0	143,769	134,655	278,424	1,305 60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	22,692	34,496	57,188	517 65.00
66.00 06600	PHYSICAL THERAPY	0	215,463	83,253	298,716	1,626 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	30,728	0	30,728	115 67.00
68.00 06800	SPEECH PATHOLOGY	0	5,882	0	5,882	95 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	109 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	3 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	132,448	215,004	347,452	930 75.00
76.00 03160	STRESS TESTING	0	0	0	0	0 76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	36,659	74,249	110,908	1,525 76.01
76.02 03610	SLEEP LAB	0	0	43,612	43,612	78 76.02
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	159 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	0	174,681	31,941	206,622	3,792 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	0 116.00
117.00 06950	HOMEMAKER	0	0	0	0	0 117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2,904,278	2,682,368	5,586,646	26,485 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,672	0	9,672	18 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	372,168	372,168	0 192.00
194.00 07950	CARDINAL SLEEP	0	0	0	0	0 194.00
194.01 07951	OTHER NRCC	0	0	0	0	0 194.01
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	0	2,913,950	3,054,536	5,968,486	26,503 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet B Part II Date/Time Prepared: 2/26/2018 11:20 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	422,435				5.00	
7.00	00700	OPERATION OF PLANT	37,172	961,900			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,558	6,554	20,680		8.00	
9.00	00900	HOUSEKEEPING	9,325	9,894	0	45,071	9.00	
10.00	01000	DIETARY	8,215	55,297	0	2,636	205,409	10.00
11.00	01100	CAFETERIA	0	0	0	0	152,250	11.00
13.00	01300	NURSING ADMINISTRATION	7,749	14,603	0	696	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,828	32,658	0	1,557	0	14.00
15.00	01500	PHARMACY	10,919	8,455	0	403	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	11,013	27,250	0	1,299	0	16.00
17.00	01700	SOCIAL SERVICE	53	4,884	0	233	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED PRGM - (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,893	126,245	7,914	6,019	41,206	30.00
31.00	03100	INTENSIVE CARE UNIT	7,468	13,394	728	638	2,074	31.00
40.00	04000	SUBPROVIDER - IPF	4,568	50,427	175	2,404	9,879	40.00
43.00	04300	NURSERY	2,302	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,814	48,212	888	2,299	0	50.00
51.00	05100	RECOVERY ROOM	6,038	5,171	0	246	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,140	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	4,661	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,674	105,849	1,031	5,046	0	54.00
58.00	05800	MRI	1,289	14,673	0	699	0	58.00
60.00	06000	LABORATORY	30,935	81,631	0	3,891	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,386	12,884	0	614	0	65.00
66.00	06600	PHYSICAL THERAPY	22,226	122,339	2,132	5,832	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,050	17,447	0	832	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,171	3,340	0	159	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,277	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,863	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,547	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,593	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,345	75,203	3,616	3,585	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,031	20,815	0	992	0	76.01
76.02	03610	SLEEP LAB	1,306	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	3,803	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	38,136	99,183	4,196	4,729	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	414,381	956,408	20,680	44,809	205,409	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	547	5,492	0	262	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,031	0	0	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	476	0	0	0	0	194.01
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)	422,435	961,900	20,680	45,071	205,409	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet B Part II Date/Time Prepared: 2/26/2018 11:20 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						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	152,250					11.00
13.00	01300	3,355	149,259				13.00
14.00	01400	631	0	318,707			14.00
15.00	01500	3,189	0	764	82,792		15.00
16.00	01600	7,637	13,912	654	0	112,816	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	29,592	53,909	6,458	0	5,641	30.00
31.00	03100	3,616	6,585	1,906	0	1,128	31.00
40.00	04000	2,888	5,260	185	0	1,128	40.00
43.00	04300	976	1,777	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,200	13,119	6,866	0	7,897	50.00
51.00	05100	3,126	5,695	1,338	0	1,128	51.00
52.00	05200	4,297	7,827	0	0	2,256	52.00
53.00	05300	1,852	0	5,337	0	3,384	53.00
54.00	05400	18,889	0	47,806	0	27,078	54.00
58.00	05800	129	0	196	0	3,384	58.00
60.00	06000	13,409	0	14,640	0	18,051	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	4,149	0	0	0	1,128	65.00
66.00	06600	12,646	0	1,165	0	4,513	66.00
67.00	06700	2,637	0	0	0	1,128	67.00
68.00	06800	578	0	69	0	0	68.00
69.00	06900	822	0	0	0	1,128	69.00
70.00	07000	22	0	0	0	1,128	70.00
71.00	07100	0	0	141,929	0	5,641	71.00
72.00	07200	0	0	77,613	0	2,256	72.00
73.00	07300	0	0	0	82,792	6,769	73.00
75.00	07500	7,025	12,796	6,687	0	4,513	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	5,392	0	414	0	1,128	76.01
76.02	03610	942	0	802	0	0	76.02
76.97	07697	1,152	0	0	0	2,256	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	15,578	28,379	3,582	0	10,153	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		151,729	149,259	318,411	82,792	112,816	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	195	0	113	0	0	190.00
192.00	19200	326	0	183	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	1,175	0	0	201.00
202.00		152,250	149,259	319,882	82,792	112,816	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet B Part II Date/Time Prepared: 2/26/2018 11:20 am		
Cost Center	Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
		17.00	19.00	23.00	24.00	25.00
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					13.00
14.00	01400					14.00
15.00	01500					15.00
16.00	01600					16.00
17.00	01700	13,772				17.00
19.00	01900	0	0			19.00
23.00	02300	0		0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	689			782,902	0 30.00
31.00	03100	138			87,955	0 31.00
40.00	04000	138			166,273	0 40.00
43.00	04300	0			5,200	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	964			742,560	0 50.00
51.00	05100	138			32,480	0 51.00
52.00	05200	275			25,432	0 52.00
53.00	05300	413			73,059	0 53.00
54.00	05400	3,304			1,075,110	0 54.00
58.00	05800	413			46,637	0 58.00
60.00	06000	2,204			444,490	0 60.00
64.00	06400	0			0	0 64.00
65.00	06500	138			85,004	0 65.00
66.00	06600	551			471,746	0 66.00
67.00	06700	138			59,075	0 67.00
68.00	06800	0			11,294	0 68.00
69.00	06900	138			3,474	0 69.00
70.00	07000	138			1,324	0 70.00
71.00	07100	689			162,122	0 71.00
72.00	07200	275			87,691	0 72.00
73.00	07300	826			109,980	0 73.00
75.00	07500	551			476,703	0 75.00
76.00	03160	0			0	0 76.00
76.01	03550	138			150,343	0 76.01
76.02	03610	0			46,740	0 76.02
76.97	07697	275			7,645	0 76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	1,239			415,589	0 91.00
92.00	09200					0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0			0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
116.00	11600	0			0	0 116.00
117.00	06950	0			0	0 117.00
118.00		13,772	0	0	5,570,828	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0			16,299	0 190.00
192.00	19200	0			379,708	0 192.00
194.00	07950	0			0	0 194.00
194.01	07951	0			476	0 194.01
200.00			0	0	0	0 200.00
201.00		0	0	0	1,175	0 201.00
202.00		13,772	0	0	5,968,486	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet B Part II Date/Time Prepared: 2/26/2018 11:20 am
-------------------------------------	--	-----------------------	---	---

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	782,902
31.00	03100	INTENSIVE CARE UNIT	87,955
40.00	04000	SUBPROVIDER - IPF	166,273
43.00	04300	NURSERY	5,200
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	742,560
51.00	05100	RECOVERY ROOM	32,480
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,432
53.00	05300	ANESTHESIOLOGY	73,059
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,075,110
58.00	05800	MRI	46,637
60.00	06000	LABORATORY	444,490
64.00	06400	INTRAVENOUS THERAPY	0
65.00	06500	RESPIRATORY THERAPY	85,004
66.00	06600	PHYSICAL THERAPY	471,746
67.00	06700	OCCUPATIONAL THERAPY	59,075
68.00	06800	SPEECH PATHOLOGY	11,294
69.00	06900	ELECTROCARDIOLOGY	3,474
70.00	07000	ELECTROENCEPHALOGRAPHY	1,324
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	162,122
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,691
73.00	07300	DRUGS CHARGED TO PATIENTS	109,980
75.00	07500	ASC (NON-DISTINCT PART)	476,703
76.00	03160	STRESS TESTING	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	150,343
76.02	03610	SLEEP LAB	46,740
76.97	07697	CARDIAC REHABILITATION	7,645
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	415,589
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
116.00	11600	HOSPICE	0
117.00	06950	HOMEMAKER	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,570,828
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,299
192.00	19200	PHYSICIANS' PRIVATE OFFICES	379,708
194.00	07950	CARDINAL SLEEP	0
194.01	07951	OTHER NRCC	476
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	1,175
202.00		TOTAL (sum lines 118 through 201)	5,968,486

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet B-1 Date/Time Prepared: 2/26/2018 11:20 am
-------------------------------------	--	-----------------------	---	--

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	236,794				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,697,450			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,104	340	38,595,587		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,359	80,746	2,893,147	-19,745,829	5.00
7.00 00700	OPERATION OF PLANT	74,665	2,854	1,124,557	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	938	0	36,053	0	8.00
9.00 00900	HOUSEKEEPING	1,416	4,304	993,426	0	9.00
10.00 01000	DIETARY	7,914	22,982	753,176	0	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,090	53,674	801,523	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	4,674	125,399	52,461	0	14.00
15.00 01500	PHARMACY	1,210	24,245	789,939	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,900	1,215	1,269,079	0	16.00
17.00 01700	SOCIAL SERVICE	699	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,068	130,902	5,004,334	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,917	14,528	796,767	0	31.00
40.00 04000	SUBPROVIDER - IPF	7,217	39	495,014	0	40.00
43.00 04300	NURSERY	0	0	210,516	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,900	303,733	1,205,725	0	50.00
51.00 05100	RECOVERY ROOM	740	0	719,513	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	927,183	0	52.00
53.00 05300	ANESTHESIOLOGY	0	31,180	1,897,960	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,149	351,497	3,637,241	0	54.00
58.00 05800	MRI	2,100	0	16,831	0	58.00
60.00 06000	LABORATORY	11,683	74,830	1,899,361	0	60.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	1,844	19,170	752,310	0	65.00
66.00 06600	PHYSICAL THERAPY	17,509	46,265	2,366,819	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	2,497	0	167,310	0	67.00
68.00 06800	SPEECH PATHOLOGY	478	0	138,061	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	158,333	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	4,043	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00 07500	ASC (NON-DISTINCT PART)	10,763	119,481	1,353,917	0	75.00
76.00 03160	STRESS TESTING	0	0	0	0	76.00
76.01 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,979	41,261	2,219,501	0	76.01
76.02 03610	SLEEP LAB	0	24,236	113,848	0	76.02
76.97 07697	CARDIAC REHABILITATION	0	0	231,732	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	14,195	17,750	5,539,000	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
116.00 11600	HOSPICE	0	0	0	0	116.00
117.00 06950	HOMEMAKER	0	0	0	0	117.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	236,008	1,490,631	38,568,680	-19,745,829	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	0	26,907	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	206,819	0	0	192.00
194.00 07950	CARDINAL SLEEP	0	0	0	0	194.00
194.01 07951	OTHER NRCC	0	0	0	0	194.01
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,913,950	3,054,536	11,945,926		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12.305844	1.799485	0.309515		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			26,503		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000687		205.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet B-1	
Date/Time Prepared: 2/26/2018 11:20 am							
Cost Center	Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
		7.00	8.00	9.00	10.00	11.00	
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	137,666					7.00
8.00	00800		546,359				8.00
9.00	00900	938		45,256			9.00
10.00	01000	1,416	0	2,647	198,673		10.00
11.00	01100	7,914	0	0	147,257	48,506	11.00
13.00	01300	0	0	699	0	1,069	13.00
14.00	01400	2,090	0	1,563	0	201	14.00
15.00	01500	4,674	0	405	0	1,016	15.00
16.00	01600	1,210	0	1,304	0	2,433	16.00
17.00	01700	3,900	0	234	0	0	17.00
19.00	01900	699	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,068	209,114	6,043	39,855	9,428	30.00
31.00	03100	1,917	19,223	641	2,006	1,152	31.00
40.00	04000	7,217	4,620	2,414	9,555	920	40.00
43.00	04300	0	0	0	0	311	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,900	23,462	2,308	0	2,294	50.00
51.00	05100	740	0	247	0	996	51.00
52.00	05200	0	0	0	0	1,369	52.00
53.00	05300	0	0	0	0	590	53.00
54.00	05400	15,149	27,235	5,067	0	6,018	54.00
58.00	05800	2,100	0	702	0	41	58.00
60.00	06000	11,683	0	3,907	0	4,272	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	1,844	0	617	0	1,322	65.00
66.00	06600	17,509	56,318	5,856	0	4,029	66.00
67.00	06700	2,497	0	835	0	840	67.00
68.00	06800	478	0	160	0	184	68.00
69.00	06900	0	0	0	0	262	69.00
70.00	07000	0	0	0	0	7	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
75.00	07500	10,763	95,525	3,600	0	2,238	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	2,979	0	996	0	1,718	76.01
76.02	03610	0	0	0	0	300	76.02
76.97	07697	0	0	0	0	367	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	14,195	110,862	4,748	0	4,963	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		136,880	546,359	44,993	198,673	48,340	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	786	0	263	0	62	190.00
192.00	19200	0	0	0	0	104	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		7,770,940	587,600	2,029,379	2,282,744	1,691,976	202.00
203.00		56.447779	1.075483	44.842209	11.489956	34.881788	203.00
204.00		961,900	20,680	45,071	205,409	152,250	204.00
205.00		6.987201	0.037851	0.995912	1.033905	3.138787	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		NURSING ADMINISTRATIVE (HOURS SUPPORTED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIREMENTS)	PHARMACY (COSTED REQUIREMENTS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		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	542,935					13.00
14.00	01400	0	5,029,941				14.00
15.00	01500	0	12,053	100			15.00
16.00	01600	50,606	10,315	0	100		16.00
17.00	01700	0	0	0	0	100	17.00
19.00	01900	0	0	0	0	0	19.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	196,094	101,920	0	5	5	30.00
31.00	03100	23,954	30,083	0	1	1	31.00
40.00	04000	19,132	2,922	0	1	1	40.00
43.00	04300	6,464	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	47,720	108,362	0	7	7	50.00
51.00	05100	20,717	21,121	0	1	1	51.00
52.00	05200	28,472	0	0	2	2	52.00
53.00	05300	0	84,225	0	3	3	53.00
54.00	05400	0	754,484	0	24	24	54.00
58.00	05800	0	3,099	0	3	3	58.00
60.00	06000	0	231,059	0	16	16	60.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	1	1	65.00
66.00	06600	0	18,382	0	4	4	66.00
67.00	06700	0	0	0	1	1	67.00
68.00	06800	0	1,082	0	0	0	68.00
69.00	06900	0	0	0	1	1	69.00
70.00	07000	0	0	0	1	1	70.00
71.00	07100	0	2,239,991	0	5	5	71.00
72.00	07200	0	1,224,908	0	2	2	72.00
73.00	07300	0	0	100	6	6	73.00
75.00	07500	46,546	105,536	0	4	4	75.00
76.00	03160	0	0	0	0	0	76.00
76.01	03550	0	6,533	0	1	1	76.01
76.02	03610	0	12,656	0	0	0	76.02
76.97	07697	0	0	0	2	2	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	103,230	56,531	0	9	9	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
116.00	11600	0	0	0	0	0	116.00
117.00	06950	0	0	0	0	0	117.00
118.00		542,935	5,025,262	100	100	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1,786	0	0	0	190.00
192.00	19200	0	2,893	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		1,806,514	723,132	2,406,345	2,835,592	61,029	202.00
203.00		3.327312	0.143766	24,063.450000	28,355.920000	610.290000	203.00
204.00		149,259	319,882	82,792	112,816	13,772	204.00
205.00		0.274911	0.063362	827.920000	1,128.160000	137.720000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet B-1
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMED PRGM (ASSIGNED TIME)	
		19.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - I/PF	0	40.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
76.00	03160	STRESS TESTING	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.01
76.02	03610	SLEEP LAB	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
117.00	06950	HOMEMAKER	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	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
194.00	07950	CARDINAL SLEEP	0	194.00
194.01	07951	OTHER NRCC	0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Hospital		Total Costs		
				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	12,290,403		12,290,403	0	12,290,403	30.00
31.00	03100	INTENSIVE CARE UNIT	1,894,963		1,894,963	0	1,894,963	31.00
40.00	04000	SUBPROVIDER - IPF	1,710,521		1,710,521	0	1,710,521	40.00
43.00	04300	NURSERY	513,671		513,671	0	513,671	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,744,569		5,744,569	0	5,744,569	50.00
51.00	05100	RECOVERY ROOM	1,450,839		1,450,839	0	1,450,839	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,320,291		2,320,291	0	2,320,291	52.00
53.00	05300	ANESTHESIOLOGY	1,094,007		1,094,007	138,942	1,232,949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,469,288		11,469,288	0	11,469,288	54.00
58.00	05800	MRI	508,356		508,356	0	508,356	58.00
60.00	06000	LABORATORY	7,947,351		7,947,351	0	7,947,351	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,959,918	0	1,959,918	0	1,959,918	65.00
66.00	06600	PHYSICAL THERAPY	6,217,010	0	6,217,010	36,464	6,253,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,501,473	0	1,501,473	0	1,501,473	67.00
68.00	06800	SPEECH PATHOLOGY	285,513	0	285,513	0	285,513	68.00
69.00	06900	ELECTROCARDIOLOGY	305,151		305,151	0	305,151	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,028		36,028	0	36,028	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,364,847		3,364,847	0	3,364,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,811,674		1,811,674	0	1,811,674	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,676,160		6,676,160	0	6,676,160	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,234,552		4,234,552	0	4,234,552	75.00
76.00	03160	STRESS TESTING	0		0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,190,525		2,190,525	14,084	2,204,609	76.01
76.02	03610	SLEEP LAB	285,261		285,261	0	285,261	76.02
76.97	07697	CARDIAC REHABILITATION	865,734		865,734	0	865,734	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,891,192		9,891,192	131,429	10,022,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,136,680		2,136,680	0	2,136,680	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
117.00	06950	HOMEMAKER	0		0		0	117.00
200.00		Subtotal (see instructions)	88,705,977	0	88,705,977	320,919	89,026,896	200.00
201.00		Less Observation Beds	2,136,680		2,136,680		2,136,680	201.00
202.00		Total (see instructions)	86,569,297	0	86,569,297	320,919	86,890,216	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/26/2018 11:20 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,018,542		17,018,542		30.00
31.00	03100	INTENSIVE CARE UNIT	2,670,154		2,670,154		31.00
40.00	04000	SUBPROVIDER - IPF	4,009,528		4,009,528		40.00
43.00	04300	NURSERY	911,624		911,624		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,976,525	18,481,693	24,458,218	0.234873	50.00
51.00	05100	RECOVERY ROOM	485,190	3,866,098	4,351,288	0.333427	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,735,481	2,937,626	6,673,107	0.347708	52.00
53.00	05300	ANESTHESIOLOGY	2,750,832	7,279,929	10,030,761	0.109065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,327,546	79,410,088	87,737,634	0.130723	54.00
58.00	05800	MRI	803,292	11,918,543	12,721,835	0.039959	58.00
60.00	06000	LABORATORY	11,959,950	47,240,956	59,200,906	0.134244	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,311,615	2,344,188	4,655,803	0.420962	65.00
66.00	06600	PHYSICAL THERAPY	579,098	14,483,910	15,063,008	0.412734	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,739	1,739,626	1,812,365	0.828461	67.00
68.00	06800	SPEECH PATHOLOGY	64,240	470,465	534,705	0.533964	68.00
69.00	06900	ELECTROCARDIOLOGY	814,436	2,485,350	3,299,786	0.092476	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,404	64,241	77,645	0.464009	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,238,690	10,630,192	17,868,882	0.188308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,163,399	4,546,451	7,709,850	0.234982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,837,922	13,720,878	23,558,800	0.283383	73.00
75.00	07500	ASC (NON-DISTINCT PART)	508,393	14,094,994	14,603,387	0.289971	75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,242	3,165,892	3,170,134	0.690988	76.01
76.02	03610	SLEEP LAB	0	1,138,742	1,138,742	0.250505	76.02
76.97	07697	CARDIAC REHABILITATION	1,652,728	7,180,111	8,832,839	0.098013	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,151,364	27,237,782	32,389,146	0.305386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,866	3,888,652	5,230,518	0.408503	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
117.00	06950	HOMEMAKER	0	0	0		117.00
200.00		Subtotal (see instructions)	91,402,800	278,326,407	369,729,207		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	91,402,800	278,326,407	369,729,207		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet C Part I Date/Time Prepared: 2/26/2018 11:20 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
40.00	04000 SUBPROVIDER - IPF			40.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.234873		50.00
51.00	05100 RECOVERY ROOM	0.333427		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.347708		52.00
53.00	05300 ANESTHESIOLOGY	0.122917		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.130723		54.00
58.00	05800 MRI	0.039959		58.00
60.00	06000 LABORATORY	0.134244		60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.420962		65.00
66.00	06600 PHYSICAL THERAPY	0.415154		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.828461		67.00
68.00	06800 SPEECH PATHOLOGY	0.533964		68.00
69.00	06900 ELECTROCARDIOLOGY	0.092476		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.464009		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.188308		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.234982		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.283383		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.289971		75.00
76.00	03160 STRESS TESTING	0.000000		76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.695431		76.01
76.02	03610 SLEEP LAB	0.250505		76.02
76.97	07697 CARDIAC REHABILITATION	0.098013		76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.309444		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.408503		92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE			116.00
117.00	06950 HOMEMAKER			117.00
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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/26/2018 11:20 am

		Title XIX		Hospital		Cost		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs					
			Total Costs	RCE Disallowance	Total Costs			
	1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,290,403		12,290,403	0	12,290,403	30.00
31.00	03100	INTENSIVE CARE UNIT	1,894,963		1,894,963	0	1,894,963	31.00
40.00	04000	SUBPROVIDER - IPF	1,710,521		1,710,521	0	1,710,521	40.00
43.00	04300	NURSERY	513,671		513,671	0	513,671	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,744,569		5,744,569	0	5,744,569	50.00
51.00	05100	RECOVERY ROOM	1,450,839		1,450,839	0	1,450,839	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,320,291		2,320,291	0	2,320,291	52.00
53.00	05300	ANESTHESIOLOGY	1,094,007		1,094,007	138,942	1,232,949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,469,288		11,469,288	0	11,469,288	54.00
58.00	05800	MRI	508,356		508,356	0	508,356	58.00
60.00	06000	LABORATORY	7,947,351		7,947,351	0	7,947,351	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,959,918	0	1,959,918	0	1,959,918	65.00
66.00	06600	PHYSICAL THERAPY	6,217,010	0	6,217,010	36,464	6,253,474	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,501,473	0	1,501,473	0	1,501,473	67.00
68.00	06800	SPEECH PATHOLOGY	285,513	0	285,513	0	285,513	68.00
69.00	06900	ELECTROCARDIOLOGY	305,151		305,151	0	305,151	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,028		36,028	0	36,028	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,364,847		3,364,847	0	3,364,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,811,674		1,811,674	0	1,811,674	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,676,160		6,676,160	0	6,676,160	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,234,552		4,234,552	0	4,234,552	75.00
76.00	03160	STRESS TESTING	0		0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,190,525		2,190,525	14,084	2,204,609	76.01
76.02	03610	SLEEP LAB	285,261		285,261	0	285,261	76.02
76.97	07697	CARDIAC REHABILITATION	865,734		865,734	0	865,734	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,891,192		9,891,192	131,429	10,022,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,136,680		2,136,680	0	2,136,680	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
117.00	06950	HOMEMAKER	0		0		0	117.00
200.00		Subtotal (see instructions)	88,705,977	0	88,705,977	320,919	89,026,896	200.00
201.00		Less Observation Beds	2,136,680		2,136,680		2,136,680	201.00
202.00		Total (see instructions)	86,569,297	0	86,569,297	320,919	86,890,216	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/26/2018 11:20 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	17,018,542		17,018,542		30.00
31.00	03100	INTENSIVE CARE UNIT	2,670,154		2,670,154		31.00
40.00	04000	SUBPROVIDER - IPF	4,009,528		4,009,528		40.00
43.00	04300	NURSERY	911,624		911,624		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,976,525	18,481,693	24,458,218	0.234873	50.00
51.00	05100	RECOVERY ROOM	485,190	3,866,098	4,351,288	0.333427	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,735,481	2,937,626	6,673,107	0.347708	52.00
53.00	05300	ANESTHESIOLOGY	2,750,832	7,279,929	10,030,761	0.109065	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,327,546	79,410,088	87,737,634	0.130723	54.00
58.00	05800	MRI	803,292	11,918,543	12,721,835	0.039959	58.00
60.00	06000	LABORATORY	11,959,950	47,240,956	59,200,906	0.134244	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	2,311,615	2,344,188	4,655,803	0.420962	65.00
66.00	06600	PHYSICAL THERAPY	579,098	14,483,910	15,063,008	0.412734	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,739	1,739,626	1,812,365	0.828461	67.00
68.00	06800	SPEECH PATHOLOGY	64,240	470,465	534,705	0.533964	68.00
69.00	06900	ELECTROCARDIOLOGY	814,436	2,485,350	3,299,786	0.092476	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,404	64,241	77,645	0.464009	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,238,690	10,630,192	17,868,882	0.188308	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,163,399	4,546,451	7,709,850	0.234982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,837,922	13,720,878	23,558,800	0.283383	73.00
75.00	07500	ASC (NON-DISTINCT PART)	508,393	14,094,994	14,603,387	0.289971	75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,242	3,165,892	3,170,134	0.690988	76.01
76.02	03610	SLEEP LAB	0	1,138,742	1,138,742	0.250505	76.02
76.97	07697	CARDIAC REHABILITATION	1,652,728	7,180,111	8,832,839	0.098013	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	5,151,364	27,237,782	32,389,146	0.305386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,866	3,888,652	5,230,518	0.408503	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
117.00	06950	HOMEMAKER	0	0	0		117.00
200.00		Subtotal (see instructions)	91,402,800	278,326,407	369,729,207		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	91,402,800	278,326,407	369,729,207		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet C
Part I
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
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
58.00	05800 MRI	0.000000			58.00
60.00	06000 LABORATORY	0.000000			60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03160 STRESS TESTING	0.000000			76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.01
76.02	03610 SLEEP LAB	0.000000			76.02
76.97	07697 CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
116.00	11600 HOSPICE				116.00
117.00	06950 HOMEMAKER				117.00
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: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet D Part I Date/Time Prepared: 2/26/2018 11:20 am		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	782,902	0	782,902	12,971	60.36	30.00	
31.00	INTENSIVE CARE UNIT	87,955		87,955	899	97.84	31.00	
40.00	SUBPROVIDER - IPF	166,273	0	166,273	2,141	77.66	40.00	
43.00	NURSERY	5,200		5,200	932	5.58	43.00	
200.00	Total (lines 30 through 199)	1,042,330		1,042,330	16,943		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	4,001	241,500					30.00
31.00	INTENSIVE CARE UNIT	563	55,084					31.00
40.00	SUBPROVIDER - IPF	1,198	93,037					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	5,762	389,621					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part II Date/Time Prepared: 2/26/2018 11:20 am
Title XVIII			Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	742,560	24,458,218	0.030360	2,904,868	88,192	50.00
51.00	05100 RECOVERY ROOM	32,480	4,351,288	0.007464	252,685	1,886	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	25,432	6,673,107	0.003811	32,996	126	52.00
53.00	05300 ANESTHESIOLOGY	73,059	10,030,761	0.007283	1,140,049	8,303	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,075,110	87,737,634	0.012254	4,339,209	53,173	54.00
58.00	05800 MRI	46,637	12,721,835	0.003666	422,919	1,550	58.00
60.00	06000 LABORATORY	444,490	59,200,906	0.007508	5,935,052	44,560	60.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	85,004	4,655,803	0.018258	1,328,399	24,254	65.00
66.00	06600 PHYSICAL THERAPY	471,746	15,063,008	0.031318	377,632	11,827	66.00
67.00	06700 OCCUPATIONAL THERAPY	59,075	1,812,365	0.032596	41,192	1,343	67.00
68.00	06800 SPEECH PATHOLOGY	11,294	534,705	0.021122	50,044	1,057	68.00
69.00	06900 ELECTROCARDIOLOGY	3,474	3,299,786	0.001053	499,394	526	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1,324	77,645	0.017052	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	162,122	17,868,882	0.009073	3,900,335	35,388	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	87,691	7,709,850	0.011374	1,810,295	20,590	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	109,980	23,558,800	0.004668	4,374,808	20,422	73.00
75.00	07500 ASC (NON-DISTINCT PART)	476,703	14,603,387	0.032643	168,772	5,509	75.00
76.00	03160 STRESS TESTING	0	0	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	150,343	3,170,134	0.047425	1,252	59	76.01
76.02	03610 SLEEP LAB	46,740	1,138,742	0.041045	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	7,645	8,832,839	0.000866	1,094,128	948	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	415,589	32,389,146	0.012831	2,445,347	31,376	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	136,107	5,230,518	0.026022	871,423	22,676	92.00
200.00	Total (lines 50 through 199)	4,664,605	345,119,359		31,990,799	373,765	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part III Date/Time Prepared: 2/26/2018 11:20 am
---	-----------------------	---	--

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col.s. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	12,971	0.00	4,001	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	899	0.00	563	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	2,141	0.00	1,198	40.00	
43.00	04300	NURSERY	0	0	932	0.00	0	43.00	
200.00		Total (lines 30 through 199)	0	0	16,943		5,762	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part IV
Date/Time Prepared:
2/26/2018 11:20 am

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
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03610	SLEEP LAB	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
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: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/26/2018 11:20 am
--	-----------------------	---	---

Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
Title XVIII								
Hospital								
PPS								
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	24,458,218	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,351,288	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,673,107	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,030,761	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	87,737,634	0.000000	54.00
58.00	05800	MRI	0	0	0	12,721,835	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	59,200,906	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,655,803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,063,008	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,812,365	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	534,705	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,299,786	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	77,645	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,868,882	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,709,850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,558,800	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	14,603,387	0.000000	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,170,134	0.000000	76.01
76.02	03610	SLEEP LAB	0	0	0	1,138,742	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	8,832,839	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	32,389,146	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,230,518	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	345,119,359		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/26/2018 11:20 am
--	-----------------------	---	---

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	2,904,868	0	8,474,558	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	252,685	0	1,843,485	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	32,996	0	1,068	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	1,140,049	0	2,497,834	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	4,339,209	0	25,127,601	0	54.00
58.00	05800 MRI	0.000000	422,919	0	3,353,605	0	58.00
60.00	06000 LABORATORY	0.000000	5,935,052	0	7,121,197	0	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,328,399	0	965,228	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	377,632	0	1,075,476	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	41,192	0	3,944	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	50,044	0	3,619	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	499,394	0	1,338,173	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,900,335	0	4,143,547	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,810,295	0	1,823,183	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	4,374,808	0	8,943,749	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	168,772	0	3,823,183	0	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	1,252	0	887,193	0	76.01
76.02	03610 SLEEP LAB	0.000000	0	0	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.000000	1,094,128	0	3,201,811	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	2,445,347	0	8,429,437	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	871,423	0	1,592,280	0	92.00
200.00	Total (lines 50 through 199)		31,990,799	0	84,650,171	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part V Date/Time Prepared: 2/26/2018 11:20 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	0.234873	8,474,558	0	0	1,990,445	50.00
51.00	05100	RECOVERY ROOM	0.333427	1,843,485	0	0	614,668	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.347708	1,068	0	0	371	52.00
53.00	05300	ANESTHESIOLOGY	0.109065	2,497,834	0	0	272,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130723	25,127,601	0	0	3,284,755	54.00
58.00	05800	MRI	0.039959	3,353,605	0	0	134,007	58.00
60.00	06000	LABORATORY	0.134244	7,121,197	14,123	0	955,978	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.420962	965,228	0	0	406,324	65.00
66.00	06600	PHYSICAL THERAPY	0.412734	1,075,476	0	0	443,886	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.828461	3,944	0	0	3,267	67.00
68.00	06800	SPEECH PATHOLOGY	0.533964	3,619	0	0	1,932	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092476	1,338,173	0	0	123,749	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.464009	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188308	4,143,547	0	0	780,263	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234982	1,823,183	0	0	428,415	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.283383	8,943,749	0	145,850	2,534,506	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.289971	3,823,183	0	0	1,108,612	75.00
76.00	03160	STRESS TESTING	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.690988	887,193	0	0	613,040	76.01
76.02	03610	SLEEP LAB	0.250505	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.098013	3,201,811	0	0	313,819	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.305386	8,429,437	0	0	2,574,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.408503	1,592,280	0	0	650,451	92.00
200.00		Subtotal (see instructions)		84,650,171	14,123	145,850	17,235,146	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		84,650,171	14,123	145,850	17,235,146	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part V Date/Time Prepared: 2/26/2018 11:20 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	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
58.00 05800 MRI	0	0		58.00
60.00 06000 LABORATORY	1,896	0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	41,331		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03160 STRESS TESTING	0	0		76.00
76.01 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.01
76.02 03610 SLEEP LAB	0	0		76.02
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS				
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)	1,896	41,331		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	1,896	41,331		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0110 Component CCN: 14-S110		Period: From 10/01/2016 To 09/30/2017		Worksheet D Part II Date/Time Prepared: 2/26/2018 11:20 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	742,560	24,458,218	0.030360	4,986	151	50.00
51.00	05100	RECOVERY ROOM	32,480	4,351,288	0.007464	1,175	9	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,432	6,673,107	0.003811	1,378	5	52.00
53.00	05300	ANESTHESIOLOGY	73,059	10,030,761	0.007283	2,619	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,075,110	87,737,634	0.012254	53,846	660	54.00
58.00	05800	MRI	46,637	12,721,835	0.003666	6,502	24	58.00
60.00	06000	LABORATORY	444,490	59,200,906	0.007508	444,934	3,341	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	85,004	4,655,803	0.018258	28,982	529	65.00
66.00	06600	PHYSICAL THERAPY	471,746	15,063,008	0.031318	11,029	345	66.00
67.00	06700	OCCUPATIONAL THERAPY	59,075	1,812,365	0.032596	1,257	41	67.00
68.00	06800	SPEECH PATHOLOGY	11,294	534,705	0.021122	1,217	26	68.00
69.00	06900	ELECTROCARDIOLOGY	3,474	3,299,786	0.001053	30,836	32	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,324	77,645	0.017052	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	162,122	17,868,882	0.009073	12,719	115	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87,691	7,709,850	0.011374	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	109,980	23,558,800	0.004668	386,553	1,804	73.00
75.00	07500	ASC (NON-DISTINCT PART)	476,703	14,603,387	0.032643	979	32	75.00
76.00	03160	STRESS TESTING	0	0	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	150,343	3,170,134	0.047425	2,373	113	76.01
76.02	03610	SLEEP LAB	46,740	1,138,742	0.041045	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	7,645	8,832,839	0.000866	6,290	5	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	415,589	32,389,146	0.012831	234,149	3,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,230,518	0.000000	11,771	0	92.00
200.00		Total (lines 50 through 199)	4,528,498	345,119,359		1,243,595	10,255	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2016 To 09/30/2017	Worksheet D Part IV Date/Time Prepared: 2/26/2018 11:20 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.01
76.02	03610	SLEEP LAB	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
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: 14-0110 Component CCN: 14-S110		Period: From 10/01/2016 To 09/30/2017		Worksheet D Part IV Date/Time Prepared: 2/26/2018 11:20 am		
				Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	24,458,218	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,351,288	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,673,107	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,030,761	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	87,737,634	0.000000	54.00
58.00	05800	MRI	0	0	0	12,721,835	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	59,200,906	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,655,803	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,063,008	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,812,365	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	534,705	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,299,786	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	77,645	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,868,882	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,709,850	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,558,800	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	14,603,387	0.000000	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	3,170,134	0.000000	76.01
76.02	03610	SLEEP LAB	0	0	0	1,138,742	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	8,832,839	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	32,389,146	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,230,518	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	345,119,359		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0110 Component CCN: 14-S110		Period: From 10/01/2016 To 09/30/2017		Worksheet D Part IV Date/Time Prepared: 2/26/2018 11:20 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	4,986	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,175	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	1,378	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,619	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	53,846	0	0	54.00
58.00	05800	MRI	0.000000	6,502	0	0	58.00
60.00	06000	LABORATORY	0.000000	444,934	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	28,982	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	11,029	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,257	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,217	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	30,836	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	12,719	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	386,553	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	979	0	0	75.00
76.00	03160	STRESS TESTING	0.000000	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	2,373	0	0	76.01
76.02	03610	SLEEP LAB	0.000000	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	6,290	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	234,149	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	11,771	0	0	92.00
200.00		Total (lines 50 through 199)		1,243,595	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 11:20 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)		12,971	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		12,971	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)		10,716	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,001	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)		12,290,403	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)		12,290,403	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)		12,290,403	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)		947.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,791,068	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,791,068	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 11:20 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	1,894,963	899	2,107.86	563	1,186,725	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,791,342	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,769,135	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)					296,584	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					373,765	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					670,349	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,098,786	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,255	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					947.53	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,136,680	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet D-1 Date/Time Prepared: 2/26/2018 11:20 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	782,902	12,290,403	0.063700	2,136,680	136,107	90.00
91.00	Nursing School cost	0	12,290,403	0.000000	2,136,680	0	91.00
92.00	Allied health cost	0	12,290,403	0.000000	2,136,680	0	92.00
93.00	All other Medical Education	0	12,290,403	0.000000	2,136,680	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 11:20 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,141	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,141	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,141	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)		1,198	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)		1,710,521	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)		1,710,521	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)		1,710,521	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)		798.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		957,130	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)		957,130	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 11:20 am
				Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					282,468	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,239,598	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)					93,037	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					10,255	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					103,292	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,136,306	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0110 Component CCN: 14-S110		Period: From 10/01/2016 To 09/30/2017		Worksheet D-1 Date/Time Prepared: 2/26/2018 11:20 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	166,273	1,710,521	0.097206	0	0	90.00
91.00	Nursing School cost	0	1,710,521	0.000000	0	0	91.00
92.00	Allied health cost	0	1,710,521	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,710,521	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/26/2018 11:20 am	
Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		5,356,358	30.00
31.00	03100	INTENSIVE CARE UNIT		1,479,391	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.234873	2,904,868	50.00
51.00	05100	RECOVERY ROOM	0.333427	252,685	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.347708	32,996	52.00
53.00	05300	ANESTHESIOLOGY	0.122917	1,140,049	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130723	4,339,209	54.00
58.00	05800	MRI	0.039959	422,919	58.00
60.00	06000	LABORATORY	0.134244	5,935,052	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.420962	1,328,399	65.00
66.00	06600	PHYSICAL THERAPY	0.415154	377,632	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.828461	41,192	67.00
68.00	06800	SPEECH PATHOLOGY	0.533964	50,044	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092476	499,394	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.464009	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188308	3,900,335	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234982	1,810,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.283383	4,374,808	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.289971	168,772	75.00
76.00	03160	STRESS TESTING	0.000000	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.695431	1,252	76.01
76.02	03610	SLEEP LAB	0.250505	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.098013	1,094,128	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.309444	2,445,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.408503	871,423	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		31,990,799	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)		31,990,799	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2016 To 09/30/2017	Worksheet D-3 Date/Time Prepared: 2/26/2018 11:20 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		2,296,035	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.234873	4,986	50.00
51.00	05100	RECOVERY ROOM	0.333427	1,175	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.347708	1,378	52.00
53.00	05300	ANESTHESIOLOGY	0.122917	2,619	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.130723	53,846	54.00
58.00	05800	MRI	0.039959	6,502	58.00
60.00	06000	LABORATORY	0.134244	444,934	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.420962	28,982	65.00
66.00	06600	PHYSICAL THERAPY	0.415154	11,029	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.828461	1,257	67.00
68.00	06800	SPEECH PATHOLOGY	0.533964	1,217	68.00
69.00	06900	ELECTROCARDIOLOGY	0.092476	30,836	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.464009	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.188308	12,719	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234982	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.283383	386,553	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.289971	979	75.00
76.00	03160	STRESS TESTING	0.000000	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.695431	2,373	76.01
76.02	03610	SLEEP LAB	0.250505	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.098013	6,290	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.309444	234,149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.408503	11,771	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,243,595	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,243,595	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 11:20 am	
		Title XVIII	Hospital	PPS	
			Before GEO Reclass	On/After GEO Reclass	
			1.00	1.01	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,069,992	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	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	0	1.04
2.00	Outlier payments for discharges. (see instructions)		17,168	0	2.00
2.01	Outlier reconciliation amount		0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	2.02
3.00	Managed Care Simulated Payments		0	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		80.82		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	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	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	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.37		30.00
31.00	Percentage of Medicaid patient days (see instructions)		40.62		31.00
32.00	Sum of lines 30 and 31		44.99		32.00
33.00	Allowable disproportionate share percentage (see instructions)		26.33	26.33	33.00
34.00	Disproportionate share adjustment (see instructions)		597,032	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 11:20 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)		0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000045270	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	270,602	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	270,602	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		270,602		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
			Before GEO Recl ass	On/After GEO Recl ass	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	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	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)		9,684,192	270,602	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	0	48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			9,954,794	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			740,545	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			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			10,695,339	59.00
60.00	Primary payer payments			1,692	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			10,693,647	61.00
62.00	Deductibles billed to program beneficiaries			1,227,996	62.00
63.00	Coinurance billed to program beneficiaries			7,784	63.00
64.00	Allowable bad debts (see instructions)			251,024	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			163,166	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			211,878	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			9,621,033	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)			-32,357	70.93
70.94	HRR adjustment amount (see instructions)			-78,909	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 11:20 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)	2017	217,725	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		9,727,492	71.00
71.01	Sequestration adjustment (see instructions)		194,550	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,540,026	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)		-7,084	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		920,086	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 (line 209 plus line 210) (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2018 11:20 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,069,992	0	0	9,069,992	9,069,992	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	17,168	0	0	17,168	17,168	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2633	0.2633	0.2633	0.2633	0	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	597,032	0	0	597,032	597,032	11.00
11.01	Uncompensated care payments	36.00	270,602	0	0	270,602	270,602	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,954,794	0	0	9,954,794	9,954,794	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,954,794	0	0	9,954,794	9,954,794	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	740,545	0	0	740,545	740,545	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2018 11:20 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	10,695,339	10,695,339	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	734,248	0	0	734,248	734,248	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,297	0	0	6,297	6,297	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	0.0000	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	740,545	0	0	740,545	740,545	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.020357		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				217,725	217,725	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0110		Period: From 10/01/2016 To 09/30/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 11:20 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,069,992	9,069,992	9,069,992	9,069,992	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	17,168	0	17,168	17,168	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2633	0.2633	0.2633		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	597,032	0	597,032	597,032	11.00
11.01	Uncompensated care payments	36.00	270,602	0	270,602	270,602	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	9,954,794	0	9,954,794	9,954,794	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	9,954,794	0	9,954,794	9,954,794	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	740,545	0	740,545	740,545	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	10,695,339	10,695,339	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 11:20 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	734,248	0	734,248	734,248	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,297	0	6,297	6,297	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	740,545	0	740,545	740,545	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	217,725		217,725	217,725	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-32,357	0	-32,357	-32,357	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-78,909	0	-78,909	-78,909	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 11:20 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		43,227	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		17,235,146	2.00
3.00	OPPS payments		12,080,789	3.00
4.00	Outlier payment (see instructions)		63,275	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		43,227	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		159,973	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)		159,973	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)		159,973	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		116,746	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (see instructions)		43,227	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		12,144,064	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,490,076	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)		9,697,215	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)		9,697,215	30.00
31.00	Primary payer payments		373	31.00
32.00	Subtotal (line 30 minus line 31)		9,696,842	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)		250,047	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		162,531	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		179,135	36.00
37.00	Subtotal (see instructions)		9,859,373	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)		9,859,373	40.00
40.01	Sequestration adjustment (see instructions)		197,187	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		9,657,742	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		4,444	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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2018 11:20 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		9,540,026		9,657,742	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)		9,540,026		9,657,742	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		0		4,444	6.01	
6.02	SETTLEMENT TO PROGRAM		7,084		0	6.02	
7.00	Total Medicare program liability (see instructions)		9,532,942		9,662,186	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0110

Period: From 10/01/2016

Worksheet E-1

Component CCN: 14-S110

To 09/30/2017

Part I
Date/Time Prepared:
2/26/2018 11:20 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		915,314		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		915,314		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		19		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		915,333		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet E-1
Part II
Date/Time Prepared:
2/26/2018 11:20 am

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part II Date/Time Prepared: 2/26/2018 11:20 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,092,978 1.00
2.00	Net IPF PPS Outlier Payments			3,631 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			5.865753 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1,096,609 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,096,609 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,096,609 18.00
19.00	Deductibles			138,684 19.00
20.00	Subtotal (line 18 minus line 19)			957,925 20.00
21.00	Coinsurance			23,912 21.00
22.00	Subtotal (line 20 minus line 21)			934,013 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			934,013 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			934,013 31.00
31.01	Sequestration adjustment (see instructions)			18,680 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			915,314 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			19 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			3,631 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet G

Date/Time Prepared:
2/26/2018 11:20 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	736,285	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	117,147,279	0	0	0	4.00
5.00	Other receivable	852,646	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-92,251,381	0	0	0	6.00
7.00	Inventory	1,678,595	0	0	0	7.00
8.00	Prepaid expenses	89,849	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	-21,601,639	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,651,634	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,227,906	0	0	0	12.00
13.00	Land improvements	2,987,640	0	0	0	13.00
14.00	Accumulated depreciation	-2,704,112	0	0	0	14.00
15.00	Buildings	82,800,019	0	0	0	15.00
16.00	Accumulated depreciation	-58,376,136	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	37,679,730	0	0	0	19.00
20.00	Accumulated depreciation	-30,289,666	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	2,435,496	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	37,760,877	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,924,454	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,924,454	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	48,336,965	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,216,558	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,241,241	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	5,441,567	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,899,366	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	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	2,019,654	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,019,654	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	12,919,020	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	35,417,945	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	35,417,945	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	48,336,965	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet G-1

Date/Time Prepared:
2/26/2018 11:20 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		41,564,789			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-6,509,434				2.00
3.00	Total (sum of line 1 and line 2)		35,055,355			0	3.00
4.00	CONTRIBUTIONS	362,590		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		362,590			0	10.00
11.00	Subtotal (line 3 plus line 10)		35,417,945			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		35,417,945			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	CONTRIBUTIONS		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: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2018 11:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	17,930,166		17,930,166	1.00
2.00	SUBPROVIDER - IPF	4,009,528		4,009,528	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	21,939,694		21,939,694	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	2,670,154		2,670,154	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	2,670,154		2,670,154	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	24,609,848		24,609,848	17.00
18.00	Ancillary services	60,299,722	247,199,973	307,499,695	18.00
19.00	Outpatient services	6,493,230	31,126,434	37,619,664	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		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PROFESSIONAL FEES	5,242,773	23,227,183	28,469,956	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	96,645,573	301,553,590	398,199,163	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		98,921,502		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)		98,921,502		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2016
To 09/30/2017

Worksheet G-3

Date/Time Prepared:
2/26/2018 11:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	398,199,163	1.00
2.00	Less contractual allowances and discounts on patients' accounts	294,213,178	2.00
3.00	Net patient revenues (line 1 minus line 2)	103,985,985	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	98,921,502	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,064,483	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	19,343	6.00
7.00	Income from investments	15,807	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	418,493	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	369,717	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	574,537	24.00
24.01	COMMUNITY HEALTH ED	18,388	24.01
24.02	MEANINGFUL USE REVENUE	-219,479	24.02
24.03	GAIN OR LOSS ON DISPOSAL OF ASSETS	200	24.03
24.04	RISK AND VALUE BASED REVENUE	76,885	24.04
25.00	Total other income (sum of lines 6-24)	1,273,891	25.00
26.00	Total (line 5 plus line 25)	6,338,374	26.00
27.00	MINORITY INTEREST AND EQUITY TRANSFER	12,847,808	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	12,847,808	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,509,434	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0110	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/26/2018 11:20 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		734,248	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,297	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)		32.24	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		740,545	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