

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: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/22/2017 12:27 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/22/2017 Time: 12:27 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 MEMORIAL MEDICAL CENTER (14-0176) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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.

Encryption Information
 ECR: Date: 11/22/2017 Time: 12:27 pm
 MSByj CPwWCX0kw6b. IPshJe7: LWr: 0
 6XqnX0pzdWAmFqRHsLE7MtODpj oRhw
 pL4f1ekPHE0ydAJ8
 PI: Date: 11/22/2017 Time: 12:27 pm
 I XmcwSTKAMJa. F5sJ2WqMZ31NI v9HO
 :: XyT0cnuE20CwEV94foBj PEn. Pmaz
 6MU00TKUKI OI DeY2

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

 Title

 Date

	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	221,922	-32,549	-52,604	0 1.00
2.00	Subprovider - IPF	0	103,567	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
5.00	Swing bed - SNF	0	0	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
200.00	Total	0	325,489	-32,549	-52,604	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: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 12:22 pm			
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 3701 DOTY ROAD	PO Box:						1.00	
2.00	City: WOODSTOCK	State: IL	Zip Code: 60098-	County: MCHENRY				2.00	
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MEMORIAL MEDICAL CENTER	140176	16974	1	07/01/1966	N	P	0
4.00	Subprovider - IPF	MMC INPATIENT PSYCHIATRY	14S176	16974	4	07/01/1992	N	P	0
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)				07/01/2016	06/30/2017		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 IPF 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.	1,063	528	29	0	2,090	0		
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: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 12:22 pm			
		Urban/Rural S	Date of Geogr				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00		
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	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)(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)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	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 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00		
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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		
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00		
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	5.00	
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 and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site		Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00			
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)			0.00	0.00	0.000000	64.00
		Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00	
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	65.00

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		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		70.00
71.00	If line 70 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
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 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
				1.00	2.00	3.00
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.			Y	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

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		V		XIX				
		1.00		2.00				
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		
Rural Providers								
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00		
		Physical	Occupational	Speech	Respiratory			
		1.00	2.00	3.00	4.00			
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N		109.00	
					1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00		
					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		
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00		
		Premiums		Losses		Insurance		
		1.00		2.00		3.00		
118.01	List amounts of malpractice premiums and paid losses:	610,848		634,545		0		
					1.00		2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02		
119.00	DO NOT USE THIS LINE					119.00		
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00		
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00		
122.00	Does the cost report contain state health or similar taxes? 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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 12:22 pm		
		1.00	2.00					
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.						134.00	
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H122				140.00	
		1.00	2.00			3.00		
141.00	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.							
	Name: CENTEGRA HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131			141.00	
142.00	Street: 385 MILLENNIUM DR.	PO Box:					142.00	
143.00	City: CRYSTAL LAKE	State: IL	Zip Code: 60012-3761				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.	Y					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N					146.00	
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N				147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N				148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N				149.00	
						1.00		
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
155.00	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)	N	N	N	N		155.00	
156.00	Hospital	N	N	N	N		156.00	
157.00	Subprovider - IPF	N	N	N	N		157.00	
158.00	Subprovider - IRF	N	N	N	N		158.00	
159.00	SUBPROVIDER	N	N	N	N		159.00	
160.00	SNF	N	N	N	N		160.00	
161.00	HOME HEALTH AGENCY	N	N	N	N		161.00	
161.00	CMHC	N	N	N	N		161.00	
						1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.		N				165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
							1.00	
167.00	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 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)						168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)						168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)					0.25	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/22/2017 12:22 pm
		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)	01/01/2016	03/31/2016	170.00
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		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 12:22 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				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)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/20/2017	Y	10/20/2017		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/22/2017 12:22 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			N	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNA		BURACKER	41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTEGRA HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(815)759-8037		ABURACKER@CENTEGRA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-2
Part II
Date/Time Prepared:
11/22/2017 12:22 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT ANALYST	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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-2
Part V
Date/Time Prepared:
11/22/2017 12:22 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	ANNA	1.00
2.00	Last Name	BURACKER	2.00
3.00	Title	SENIOR REIMBURSEMENT ANALYST	3.00
4.00	Employer	CENTEGRA HEALTH SYSTEM	4.00
5.00	Phone Number	(815)759-8037	5.00
6.00	E-mail Address	ABURACKER@CENTEGRA.COM	6.00
7.00	Department	FINANCE	7.00
8.00	Mailing Address 1	527 W. SOUTH STREET	8.00
9.00	Mailing Address 2		9.00
10.00	City	WOODSTOCK	10.00
11.00	State	IL	11.00
12.00	Zip	60098	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	MICHAEL	13.00
14.00	Last Name	EESLEY	14.00
15.00	Title	CHIEF EXECUTIVE OFFICER	15.00
16.00	Employer	CENTEGRA HEALTH SYSTEM	16.00
17.00	Phone Number	(815)788-5800	17.00
18.00	E-mail Address	MEESLEY@CENTEGRA.COM	18.00
19.00	Department	ADMINISTRATION	19.00
20.00	Mailing Address 1	385 MILLENNIUM DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	CRYSTAL LAKE	22.00
23.00	State	IL	23.00
24.00	Zip	60012	24.00

HFS Supplemental Information		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part IX Date/Time Prepared: 11/22/2017 12:22 pm
		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FOHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	92	28,684	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)		92	28,684	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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						13.00
14.00 Total (see instructions)		104	33,064	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	4,896		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						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		104				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6,705	946	14,448			1.00
2.00 HMO and other (see instructions)	757	2,642				2.00
3.00 HMO IPF Subprovider	65	906				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,705	946	14,448			7.00
8.00 INTENSIVE CARE UNIT	1,039	104	1,737			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)	7,744	1,050	16,185	0.00	480.34	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	829	611	3,727	0.00	16.96	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	497.30	27.00
28.00 Observation Bed Days		22	1,409			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,714	114	3,776	1.00
2.00	HMO and other (see instructions)			175	581		2.00
3.00	HMO IPF Subprovider				179		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	1,714	114	3,776	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	103	46	557	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
11/22/2017 12:22 pm

	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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 II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	40,014,415	-7,140,675	32,873,740	1,034,378.00	31.78
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
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)		2,962,487	183,797	3,146,284	88,282.00	35.64
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,937,427	0	1,937,427	43,863.07	44.17
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		186,669	0	186,669	1,380.00	135.27
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		11,482,939	0	11,482,939	256,056.00	44.85
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		8,408	0	8,408	49.00	171.59
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)		7,626,645	0	7,626,645		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		744,548	0	744,548		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
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		1,763,730	0	1,763,730		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-170,760	189,847	19,087	961.00	19.86
27.00	Administrative & General	5.00	8,813,767	-8,246,955	566,812	28,102.00	20.17

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
11/22/2017 12:22 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
						1.00	2.00
28.00	Administrative & General under contract (see inst.)	1,132,538	0	1,132,538	37,218.00	30.43	28.00
29.00	Maintenance & Repairs	617,832	-3,700	614,132	21,578.00	28.46	29.00
30.00	Operation of Plant	1,100,918	-6,740	1,094,178	48,884.00	22.38	30.00
31.00	Laundry & Linen Service	63,493	-145	63,348	2,615.00	24.22	31.00
32.00	Housekeeping	1,025,887	-5,219	1,020,668	62,867.00	16.24	32.00
33.00	Housekeeping under contract (see instructions)	205,315	0	205,315	9,285.00	22.11	33.00
34.00	Dietary	1,037,013	-604,341	432,672	27,785.00	15.57	34.00
35.00	Dietary under contract (see instructions)	85,935	0	85,935	1,877.00	45.78	35.00
36.00	Cafeteria	0	598,325	598,325	32,854.00	18.21	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,212,572	-3,898	1,208,674	25,996.00	46.49	38.00
39.00	Central Services and Supply	361,524	-1,529	359,995	18,733.00	19.22	39.00
40.00	Pharmacy	2,140,261	-7,751	2,132,510	48,008.00	44.42	40.00
41.00	Medical Records & Medical Records Library	0	0	0	0.00	0.00	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part III
Date/Time Prepared:
11/22/2017 12:22 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	41,438,203	-7,140,675	34,297,528	1,082,758.00	31.68	1.00
2.00	Excluded area salaries (see instructions)	2,962,487	183,797	3,146,284	88,282.00	35.64	2.00
3.00	Subtotal salaries (line 1 minus line 2)	38,475,716	-7,324,472	31,151,244	994,476.00	31.32	3.00
4.00	Subtotal other wages & related costs (see inst.)	13,615,443	0	13,615,443	301,348.07	45.18	4.00
5.00	Subtotal wage-related costs (see inst.)	9,390,375	0	9,390,375	0.00	30.14	5.00
6.00	Total (sum of lines 3 thru 5)	61,481,534	-7,324,472	54,157,062	1,295,824.07	41.79	6.00
7.00	Total overhead cost (see instructions)	17,626,295	-8,092,106	9,534,189	366,763.00	26.00	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/22/2017 12:22 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	442,665	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	15,368	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)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,600,728	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	136,553	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	63,867	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)	279,340	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	322,134	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,381,922	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	15,666	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	112,950	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,371,193	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: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part V Date/Time Prepared: 11/22/2017 12:22 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,937,427	8,371,193	1.00
2.00	Hospital	1,937,427	7,626,645	2.00
3.00	Subprovider - IPF	0	351,360	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	393,188	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/22/2017 12:22 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.275274	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		7,065,714	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 or supplemental payments from Medicaid?		N	4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid		35,678	5.00	
6.00	Medicaid charges		58,424,455	6.00	
7.00	Medicaid cost (line 1 times line 6)		16,082,733	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)		8,981,341	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)		8,981,341	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	4,881,262	1,080,743	5,962,005	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,343,685	1,080,743	2,424,428	21.00
22.00	Payments received from patients for amounts previously written off as charity care	103,638	33,456	137,094	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,240,047	1,047,287	2,287,334	23.00
			1.00		
24.00	Does the amount in 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)			6,071,938	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			700,438	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,077,597	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			4,994,341	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,751,971	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,039,305	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			13,020,646	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet A Date/Time Prepared: 11/22/2017 12:22 pm		
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (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		15,372,309	15,372,309	-10,544,221	4,828,088	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,168,649	3,168,649	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-170,760	7,982,279	7,811,519	409,990	8,221,509	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,813,767	13,509,135	22,322,902	6,004,022	28,326,924	5.00
6.00	00600	MAINTENANCE & REPAIRS	617,832	902,295	1,520,127	-3,700	1,516,427	6.00
7.00	00700	OPERATION OF PLANT	1,100,918	1,236,829	2,337,747	-6,740	2,331,007	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	63,493	327,145	390,638	-145	390,493	8.00
9.00	00900	HOUSEKEEPING	1,025,887	793,603	1,819,490	-5,219	1,814,271	9.00
10.00	01000	DIETARY	1,037,013	1,209,841	2,246,854	-1,209,293	1,037,561	10.00
11.00	01100	CAFETERIA	0	0	0	1,203,277	1,203,277	11.00
13.00	01300	NURSING ADMINISTRATION	1,212,572	80,889	1,293,461	-74,005	1,219,456	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	361,524	978,266	1,339,790	-4,617	1,335,173	14.00
15.00	01500	PHARMACY	2,140,261	6,628,102	8,768,363	-5,932,179	2,836,184	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	272	272	0	272	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,866,399	932,608	7,799,007	754,723	8,553,730	30.00
31.00	03100	INTENSIVE CARE UNIT	1,323,765	520,435	1,844,200	30,585	1,874,785	31.00
40.00	04000	SUBPROVIDER - I/PF	1,343,732	106,664	1,450,396	199,465	1,649,861	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,793,776	6,999,868	10,793,644	-4,493,809	6,299,835	50.00
53.00	05300	ANESTHESIOLOGY	1,472	189,501	190,973	-7,324	183,649	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,601,453	861,423	2,462,876	-144,252	2,318,624	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	170,514	211,657	382,171	-1,372	380,799	56.00
57.00	05700	CT SCAN	444,163	296,308	740,471	-18,287	722,184	57.00
58.00	05800	MRI	192,863	79,076	271,939	-1,304	270,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	2,143,917	2,143,917	-44,609	2,099,308	60.00
65.00	06500	RESPIRATORY THERAPY	720,171	226,120	946,291	-21,125	925,166	65.00
66.00	06600	PHYSICAL THERAPY	265,974	5,311	271,285	-1,329	269,956	66.00
67.00	06700	OCCUPATIONAL THERAPY	73,031	860	73,891	-341	73,550	67.00
68.00	06800	SPEECH PATHOLOGY	105,094	2,689	107,783	-826	106,957	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	760,832	216,114	976,946	-18,287	958,659	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,867,220	3,867,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,413,661	1,413,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,900,079	5,900,079	73.00
76.00	03951	CARDIOLOGY	53,993	15,086	69,079	-257	68,822	76.00
76.01	03950	WOUND CARE	823,782	1,400,126	2,223,908	-736,879	1,487,029	76.01
76.97	07697	CARDIAC REHABILITATION	285,696	17,387	303,083	-1,850	301,233	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	380,819	380,819	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	767,290	38,584	805,874	-6,207	799,667	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	2,599,153	935,128	3,534,281	-47,044	3,487,237	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,395,660	64,219,827	102,615,487	7,269	102,622,756	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.02	19002	CRISIS PROGRAM	1,618,755	39,382	1,658,137	-7,269	1,650,868	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	40,014,415	64,259,209	104,273,624	0	104,273,624	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,825,425	3,002,663	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-8,578	3,160,071	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,221,509	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,121,164	15,205,760	5.00
6.00	00600	MAINTENANCE & REPAIRS	-33,343	1,483,084	6.00
7.00	00700	OPERATION OF PLANT	-181,033	2,149,974	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	390,493	8.00
9.00	00900	HOUSEKEEPING	-127,751	1,686,520	9.00
10.00	01000	DIETARY	0	1,037,561	10.00
11.00	01100	CAFETERIA	-508,836	694,441	11.00
13.00	01300	NURSING ADMINISTRATION	334,347	1,553,803	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,335,173	14.00
15.00	01500	PHARMACY	-1,429,338	1,406,846	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,241,100	1,241,372	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-43,750	8,509,980	30.00
31.00	03100	INTENSIVE CARE UNIT	-20,014	1,854,771	31.00
40.00	04000	SUBPROVIDER - IPF	-61,004	1,588,857	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-52,531	6,247,304	50.00
53.00	05300	ANESTHESIOLOGY	-3,622	180,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-15,249	2,303,375	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	380,799	56.00
57.00	05700	CT SCAN	0	722,184	57.00
58.00	05800	MRI	0	270,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	2,099,308	60.00
65.00	06500	RESPIRATORY THERAPY	-51,000	874,166	65.00
66.00	06600	PHYSICAL THERAPY	-1,970	267,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	73,550	67.00
68.00	06800	SPEECH PATHOLOGY	0	106,957	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	3,724	962,383	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,867,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,413,661	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,900,079	73.00
76.00	03951	CARDIOLOGY	0	68,822	76.00
76.01	03950	WOUND CARE	-78,550	1,408,479	76.01
76.97	07697	CARDIAC REHABILITATION	-856	300,377	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	-17,419	363,400	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	799,667	90.03
90.04	09004	DIABETES CENTER	0	0	90.04
91.00	09100	EMERGENCY	-174,945	3,312,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-16,177,207	86,445,549	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.02	19002	CRISIS PRGRAM	0	1,650,868	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-16,177,207	88,096,417	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet Non-CMS W
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
31.00 INTENSIVE CARE UNIT	03100		31.00
40.00 SUBPROVIDER - IPF	04000		40.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00 RADIOLOGY - THERAPEUTIC	05500		55.00
56.00 RADIOISOTOPE	05600		56.00
57.00 CT SCAN	05700		57.00
58.00 MRI	05800		58.00
59.00 CARDIAC CATHETERIZATION	05900		59.00
60.00 LABORATORY	06000		60.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
70.00 ELECTROENCEPHALOGRAPHY	07000		70.00
70.01 SLEEP LAB/NEUROLOGY	07001		70.01
71.00 MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
76.00 CARDIOLOGY	03951		76.00
76.01 WOUND CARE	03950		76.01
76.97 CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
76.98 HYPERBARIC OXYGEN THERAPY	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00 CLINIC	09000		90.00
90.01 WOMENS CENTER	09001		90.01
90.02 PSYCH SERVICES	09002		90.02
90.03 OP BEHAVIORAL HEALTH	09003		90.03
90.04 DIABETES CENTER	09004		90.04
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS			
113.00 INTEREST EXPENSE	11300		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS			
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.02 CRISIS PROGRAM	19002		190.02
191.00 RESEARCH	19100		191.00
192.00 PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00 TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6
Date/Time Prepared:
11/22/2017 12:22 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EQUIPMENT DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,083,117	1.00
	O		0	3,083,117	
B - EQUIPMENT INTEREST					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	85,532	1.00
	O		0	85,532	
C - NON-CAPITAL RELATED COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231,008	1.00
	O		0	231,008	
D - NON-CAPITAL INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	854,391	1.00
	O		0	854,391	
E - WORKERS COMP INSURANCE					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	220,143	1.00
	O		0	220,143	
F - PROVIDER TAX					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,532,046	1.00
	O		0	6,532,046	
H - CHARGABLE DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,900,079	1.00
	O		0	5,900,079	
I - MED SUPPLIES & IMPLANTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,867,220	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,413,661	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
	O		0	5,280,881	
J - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	598,325	604,952	1.00
	O		598,325	604,952	
K - ATO RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	189,847	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00

RECLASSIFICATIONS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6

Date/Time Prepared:
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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
			189,847	0	
L - CENTEGRA ALLOCATION					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,140,675	1.00
			0	7,140,675	
N - CASE MANAGEMENT/SOCIAL SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	794,609	32,588	1.00
2.00	INTENSIVE CARE UNIT	31.00	95,531	3,918	2.00
3.00	SUBPROVIDER - IPF	40.00	204,977	8,406	3.00
			1,095,117	44,912	
P - HYPERBARIC COSTS					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	217,826	162,993	1.00
			217,826	162,993	
500.00	Grand Total: Increases		2,101,115	30,140,729	500.00

RECLASSIFICATIONS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6
Date/Time Prepared:
11/22/2017 12:22 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - EQUIPMENT DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,083,117	9	1.00
	O		0	3,083,117		
B - EQUIPMENT INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	85,532	11	1.00
	O		0	85,532		
C - NON-CAPITAL RELATED COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	231,008	14	1.00
	O		0	231,008		
D - NON-CAPITAL INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	854,391	12	1.00
	O		0	854,391		
E - WORKERS COMP INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	220,143	12	1.00
	O		0	220,143		
F - PROVIDER TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,532,046	13	1.00
	O		0	6,532,046		
H - CHARGABLE DRUG COSTS						
1.00	PHARMACY	15.00	0	5,900,079	0	1.00
	O		0	5,900,079		
I - MED SUPPLIES & IMPLANTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	215	0	1.00
2.00	NURSING ADMINISTRATION	13.00	0	70,107	0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,088	0	3.00
4.00	PHARMACY	15.00	0	24,349	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	38,937	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	61,230	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	7	0	7.00
8.00	OPERATING ROOM	50.00	0	4,465,558	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	7,324	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	135,789	0	10.00
11.00	RADIOISOTOPE	56.00	0	147	0	11.00
12.00	CT SCAN	57.00	0	15,461	0	12.00
13.00	MRI	58.00	0	710	0	13.00
14.00	LABORATORY	60.00	0	44,609	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	17,424	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	8	0	16.00
17.00	SLEEP LAB/NEUROLOGY	70.01	0	13,213	0	17.00
18.00	CARDIOLOGY	76.00	0	75	0	18.00
19.00	WOUND CARE	76.01	0	350,551	0	19.00
20.00	EMERGENCY	91.00	0	32,079	0	20.00
	O		0	5,280,881		
J - CAFETERIA RECLASS						
1.00	DIETARY	10.00	598,325	604,952	0	1.00
	O		598,325	604,952		
K - ATO RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	11,163	0	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	3,700	0	0	2.00
3.00	OPERATION OF PLANT	7.00	6,740	0	0	3.00
4.00	LAUNDRY & LIEN SERVICE	8.00	145	0	0	4.00
5.00	HOUSEKEEPING	9.00	5,219	0	0	5.00
6.00	DIETARY	10.00	6,016	0	0	6.00
7.00	NURSING ADMINISTRATION	13.00	3,898	0	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	1,529	0	0	8.00
9.00	PHARMACY	15.00	7,751	0	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	33,537	0	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	7,634	0	0	11.00
12.00	SUBPROVIDER - IPF	40.00	13,911	0	0	12.00
13.00	OPERATING ROOM	50.00	28,251	0	0	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	8,463	0	0	14.00
15.00	RADIOISOTOPE	56.00	1,225	0	0	15.00
16.00	CT SCAN	57.00	2,826	0	0	16.00
17.00	MRI	58.00	594	0	0	17.00
18.00	RESPIRATORY THERAPY	65.00	3,701	0	0	18.00
19.00	PHYSICAL THERAPY	66.00	1,321	0	0	19.00
20.00	OCCUPATIONAL THERAPY	67.00	341	0	0	20.00
21.00	SPEECH PATHOLOGY	68.00	826	0	0	21.00
22.00	SLEEP LAB/NEUROLOGY	70.01	5,074	0	0	22.00
23.00	CARDIOLOGY	76.00	182	0	0	23.00
24.00	WOUND CARE	76.01	5,509	0	0	24.00
25.00	CARDIAC REHABILITATION	76.97	1,850	0	0	25.00
26.00	OP BEHAVIORAL HEALTH	90.03	6,207	0	0	26.00
27.00	EMERGENCY	91.00	14,965	0	0	27.00

RECLASSIFICATIONS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6

Date/Time Prepared:
11/22/2017 12:22 pm

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.	
	6.00	7.00	8.00	9.00	10.00		
28.00	CRI SIS PRGRAM	190.02	7,269	0	0	0	28.00
			189,847	0			
L - CENTEGRA ALLOCATI ON							
1.00	ADMI NI STRATI VE & GENERAL	5.00	7,140,675	0	0	0	1.00
			7,140,675	0			
N - CASE MANAGEMENT/SOCI AL SERVI CES							
1.00	ADMI NI STRATI VE & GENERAL	5.00	1,095,117	44,912	0	0	1.00
2.00		0.00	0	0	0	0	2.00
3.00		0.00	0	0	0	0	3.00
			1,095,117	44,912			
P - HYPERBARI C COSTS							
1.00	WOUND CARE	76.01	217,826	162,993	0	0	1.00
			217,826	162,993			
500.00	Grand Total: Decreases		9,241,790	23,000,054			500.00

RECLASSIFICATIONS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
11/22/2017 12:22 pm

		Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - EQUIPMENT DEPRECIATION										
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,083,117	CAP REL COSTS-BLDG & FIXT	1.00	0	3,083,117	1.00	
	0		0	3,083,117	0		0	3,083,117		
B - EQUIPMENT INTEREST										
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	85,532	CAP REL COSTS-BLDG & FIXT	1.00	0	85,532	1.00	
	0		0	85,532	0		0	85,532		
C - NON-CAPITAL RELATED COSTS										
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	231,008	ADMINISTRATIVE & GENERAL	5.00	0	231,008	1.00	
	0		0	231,008	0		0	231,008		
D - NON-CAPITAL INSURANCE										
1.00	ADMINISTRATIVE & GENERAL	5.00	0	854,391	CAP REL COSTS-BLDG & FIXT	1.00	0	854,391	1.00	
	0		0	854,391	0		0	854,391		
E - WORKERS COMP INSURANCE										
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	220,143	CAP REL COSTS-BLDG & FIXT	1.00	0	220,143	1.00	
	0		0	220,143	0		0	220,143		
F - PROVIDER TAX										
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,532,046	CAP REL COSTS-BLDG & FIXT	1.00	0	6,532,046	1.00	
	0		0	6,532,046	0		0	6,532,046		
H - CHARGABLE DRUG COSTS										
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,900,079	PHARMACY	15.00	0	5,900,079	1.00	
	0		0	5,900,079	0		0	5,900,079		
I - MED SUPPLIES & IMPLANTS										
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,867,220	ADMINISTRATIVE & GENERAL	5.00	0	215	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,413,661	NURSING	13.00	0	70,107	2.00	
3.00		0.00	0	0	ADMINISTRATION	14.00	0	3,088	3.00	
4.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	0	3,088	3.00	
5.00		0.00	0	0	PHARMACY	15.00	0	24,349	4.00	
6.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	38,937	5.00	
7.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	61,230	6.00	
8.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	7	7.00	
9.00		0.00	0	0	OPERATING ROOM	50.00	0	4,465,558	8.00	
10.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	7,324	9.00	
11.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	135,789	10.00	
12.00		0.00	0	0	RADIOISOTOPE	56.00	0	147	11.00	
13.00		0.00	0	0	CT SCAN	57.00	0	15,461	12.00	
14.00		0.00	0	0	MRI	58.00	0	710	13.00	
15.00		0.00	0	0	LABORATORY	60.00	0	44,609	14.00	
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	17,424	15.00	
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	8	16.00	
18.00		0.00	0	0	SLEEP LAB/NEUROLOGY	70.01	0	13,213	17.00	
19.00		0.00	0	0	CARDIOLOGY	76.00	0	75	18.00	
20.00		0.00	0	0	WOUND CARE	76.01	0	350,551	19.00	
	0		0	5,280,881	EMERGENCY	91.00	0	32,079	20.00	
	0		0	5,280,881	0		0	5,280,881		
J - CAFETERIA RECLASS										
1.00	CAFETERIA	11.00	598,325	604,952	DIETARY	10.00	598,325	604,952	1.00	
	0		598,325	604,952	0		598,325	604,952		
K - ATO RECLASS										
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	189,847	0	ADMINISTRATIVE & GENERAL	5.00	11,163	0	1.00	
2.00		0.00	0	0	MAINTENANCE & REPAIRS	6.00	3,700	0	2.00	
3.00		0.00	0	0	OPERATION OF PLANT	7.00	6,740	0	3.00	
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	145	0	4.00	
5.00		0.00	0	0	HOUSEKEEPING	9.00	5,219	0	5.00	
6.00		0.00	0	0	DIETARY	10.00	6,016	0	6.00	
7.00		0.00	0	0	NURSING	13.00	3,898	0	7.00	
8.00		0.00	0	0	ADMINISTRATION	14.00	1,529	0	8.00	
9.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	1,529	0	8.00	
10.00		0.00	0	0	PHARMACY	15.00	7,751	0	9.00	
11.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	33,537	0	10.00	
12.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	7,634	0	11.00	
13.00		0.00	0	0	SUBPROVIDER - IPF	40.00	13,911	0	12.00	
14.00		0.00	0	0	OPERATING ROOM	50.00	28,251	0	13.00	
		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	8,463	0	14.00	

	Increases				Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
15.00		0.00	0		0	RADIOISOTOPE	56.00	1,225	0	15.00
16.00		0.00	0		0	CT SCAN	57.00	2,826	0	16.00
17.00		0.00	0		0	MRI	58.00	594	0	17.00
18.00		0.00	0		0	RESPIRATORY THERAPY	65.00	3,701	0	18.00
19.00		0.00	0		0	PHYSICAL THERAPY	66.00	1,321	0	19.00
20.00		0.00	0		0	OCCUPATIONAL THERAPY	67.00	341	0	20.00
21.00		0.00	0		0	SPEECH PATHOLOGY	68.00	826	0	21.00
22.00		0.00	0		0	SLEEP LAB/NEUROLOGY	70.01	5,074	0	22.00
23.00		0.00	0		0	CARDIOLOGY	76.00	182	0	23.00
24.00		0.00	0		0	WOUND CARE	76.01	5,509	0	24.00
25.00		0.00	0		0	CARDIAC REHABILITATION	76.97	1,850	0	25.00
26.00		0.00	0		0	OP BEHAVIORAL HEALTH	90.03	6,207	0	26.00
27.00		0.00	0		0	EMERGENCY	91.00	14,965	0	27.00
28.00		0.00	0		0	CRISIS PROGRAM	190.02	7,269	0	28.00
			189,847					189,847		
L - CENTEGRA ALLOCATION										
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,140,675	ADMINISTRATIVE & GENERAL	5.00	7,140,675	0	0	1.00
			0	7,140,675			7,140,675	0	0	
N - CASE MANAGEMENT/SOCIAL SERVICES										
1.00	ADULTS & PEDIATRICS	30.00	794,609	32,588	ADMINISTRATIVE & GENERAL	5.00	1,095,117	44,912	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	95,531	3,918		0.00	0	0	0	2.00
3.00	SUBPROVIDER - IPF	40.00	204,977	8,406		0.00	0	0	0	3.00
			1,095,117	44,912			1,095,117	44,912		
P - HYPERBARIC COSTS										
1.00	HYPERBARIC OXYGEN THERAPY	76.98	217,826	162,993	WOUND CARE	76.01	217,826	162,993	0	1.00
			217,826	162,993			217,826	162,993		
500.00	Grand Total: Increases		2,101,115	30,140,729	Grand Total: Decreases		9,241,790	23,000,054		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	219,885	0	0	0	0	1.00
2.00	Land Improvements	3,212,830	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	75,711,387	47,184	0	47,184	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	56,618,714	337,374	0	337,374	0	6.00
7.00	HIT designated Assets	9,336,651	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,099,467	384,558	0	384,558	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	145,099,467	384,558	0	384,558	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	219,885	0				1.00
2.00	Land Improvements	3,212,830	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	75,758,571	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	56,956,088	0				6.00
7.00	HIT designated Assets	9,336,651	0				7.00
8.00	Subtotal (sum of lines 1-7)	145,484,025	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	145,484,025	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part II
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	15,372,309	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,372,309	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	15,372,309				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	15,372,309				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part III
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	79,191,286	0	79,191,286	0.544330	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	66,292,739	0	66,292,739	0.455670	0	2.00
3.00	Total (sum of lines 1-2)	145,484,025	0	145,484,025	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	12,289,192	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,074,539	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,363,731	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-1,910,957	-1,074,534	-6,532,046	231,008	3,002,663	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	85,532	0	0	0	3,160,071	2.00
3.00	Total (sum of lines 1-2)	-1,825,425	-1,074,534	-6,532,046	231,008	6,162,734	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8

Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,316,591	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)	A	-177,038	OPERATION OF PLANT		7.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-583,526				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	-4,595,241				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-500,020	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-152	MEDICAL RECORDS & LIBRARY		16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 EDUCATION INCOME	B	-1,395	NURSING ADMINISTRATION		13.00	0 33.00
34.00 OTHER INCOME	B	-22,800	NURSING ADMINISTRATION		13.00	0 34.00

Provider CCN: 14-0176 Period: From 07/01/2016 To 06/30/2017 Worksheet A-8
 Date/Time Prepared: 11/22/2017 12:22 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
35.00 EDUCATION INCOME	B	-8,977	ADMINISTRATIVE & GENERAL		5.00	0 35.00
36.00 OTHER INCOME	B	-50	SUBPROVIDER - IPF		40.00	0 36.00
37.00 MISCELLANEOUS INCOME	B	-225,474	ADMINISTRATIVE & GENERAL		5.00	0 37.00
38.00 PHARMACY RETAIL INCOME	B	-1,429,338	PHARMACY		15.00	0 38.00
39.00 ENDOSCOPY INCOME	B	-15,872	OPERATING ROOM		50.00	0 39.00
40.00 OPERATION PLANT	B	-33,343	MAINTENANCE & REPAIRS		6.00	0 40.00
41.00 HOUSEKEEPING OTHER REVENUE	B	-127,751	HOUSEKEEPING		9.00	0 41.00
42.00 2012 & 2014 INTEREST EXPENSE	A	-508,581	CAP REL COSTS-BLDG & FIXT		1.00	11 42.00
43.00 2012 & 2014 INTEREST INCOME	B	-253	CAP REL COSTS-BLDG & FIXT		1.00	11 43.00
44.00 PATIENT TELEPHONE CRC OFFSET	A	-8,578	CAP REL COSTS-MVBLE EQUIP		2.00	9 44.00
45.00 MEALS ON WHEELS	B	-8,816	CAFETERIA		11.00	0 45.00
45.01 POM RELATED RENTAL	A	-3,995	OPERATION OF PLANT		7.00	0 45.01
45.02 WOUND CARE RENTAL	A	-59,951	WOUND CARE		76.01	0 45.02
45.03 HBOT RENTAL	A	-17,419	HYPERBARIC OXYGEN THERAPY		76.98	0 45.03
45.04 IDPA PROVIDER TAX	A	-6,532,046	ADMINISTRATIVE & GENERAL		5.00	0 45.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,177,207				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: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:
11/22/2017 12:22 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
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	CENTEGRA ALLOCATION	14,222,524	20,430,220 1.00
2.00	13.00	NURSING ADMINISTRATION	CENTEGRA ALLOCATION	311,045	0 2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	CENTEGRA ALLOCATION	1,241,252	0 3.00
4.00	91.00	EMERGENCY	CENTEGRA ALLOCATION	164,431	0 4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA INSURANCE SERVICES	506,575	610,848 4.01
5.00	0			16,445,827	21,041,068 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	CENTEGRA HEALTH	0.00	6.00
7.00	B	0.00	CENTEGRA INSURA	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: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:
11/22/2017 12:22 pm

	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	-6,207,696	0		1.00
2.00	311,045	0		2.00
3.00	1,241,252	0		3.00
4.00	164,431	0		4.00
4.01	-104,273	0		4.01
5.00	-4,595,241			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	INSURANCE SERVI		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: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-2

Date/Time Prepared:
11/22/2017 12:22 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	INTENSIVE CARE UNIT	30,554	0	30,554	197,500	111	1.00
2.00	40.00	SUBPROVIDER - IPF	60,954	60,954	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	43,750	43,750	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	-47,497	-47,497	0	0	0	4.00
5.00	50.00	OPERATING ROOM	53,125	9,375	43,750	246,400	139	5.00
6.00	53.00	DR. AA	12,600	0	12,600	239,400	78	6.00
7.00	53.00	DR. AB	16,550	0	16,550	239,400	539	7.00
8.00	91.00	EMERGENCY	340,393	329,977	10,416	211,500	10	8.00
9.00	54.00	DR. AC	43,469	70	43,399	271,900	222	9.00
10.00	54.00	DR. AD	4,000	800	3,200	211,500	161	10.00
11.00	76.97	CARDIAC REHABILITATION	3,500	-350	3,850	211,500	26	11.00
12.00	65.00	RESPIRATORY THERAPY	51,000	51,000	0	0	0	12.00
13.00	76.01	WOUND CARE	24,700	10,400	14,300	211,500	60	13.00
14.00	70.01	SLEEP LAB/NEUROLOGY	-470	-6,770	6,300	211,500	32	14.00
15.00	66.00	PHYSICAL THERAPY	2,275	525	1,750	211,500	3	15.00
16.00	5.00	ADMINISTRATIVE & GENERAL	37,946	37,946	0	0	0	16.00
17.00	5.00	DR. AE	3,323	1,223	2,100	211,500	13	17.00
18.00	5.00	DR. AF	2,100	0	2,100	211,500	5	18.00
19.00	5.00	DR. AG	4,209	0	4,209	211,500	30	19.00
200.00			686,481	491,403	195,078		1,429	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	31.00	INTENSIVE CARE UNIT	10,540	527	0	0	0	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	16,466	823	0	0	0	5.00
6.00	53.00	DR. AA	8,978	449	0	0	0	6.00
7.00	53.00	DR. AB	62,037	3,102	0	0	0	7.00
8.00	91.00	EMERGENCY	1,017	51	0	0	0	8.00
9.00	54.00	DR. AC	29,020	1,451	0	0	0	9.00
10.00	54.00	DR. AD	16,371	819	0	0	0	10.00
11.00	76.97	CARDIAC REHABILITATION	2,644	132	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	12.00
13.00	76.01	WOUND CARE	6,101	305	0	0	0	13.00
14.00	70.01	SLEEP LAB/NEUROLOGY	3,254	163	0	0	0	14.00
15.00	66.00	PHYSICAL THERAPY	305	15	0	0	0	15.00
16.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	16.00
17.00	5.00	DR. AE	1,322	66	0	0	0	17.00
18.00	5.00	DR. AF	508	25	0	0	0	18.00
19.00	5.00	DR. AG	3,050	153	0	0	0	19.00
200.00			161,613	8,081	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	31.00	INTENSIVE CARE UNIT	0	10,540	20,014	20,014	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	60,954	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	43,750	3.00
4.00	13.00	NURSING ADMINISTRATION	0	0	0	-47,497	4.00
5.00	50.00	OPERATING ROOM	0	16,466	27,284	36,659	5.00
6.00	53.00	DR. AA	0	8,978	3,622	3,622	6.00
7.00	53.00	DR. AB	0	62,037	0	0	7.00
8.00	91.00	EMERGENCY	0	1,017	9,399	339,376	8.00
9.00	54.00	DR. AC	0	29,020	14,379	14,449	9.00
10.00	54.00	DR. AD	0	16,371	0	800	10.00
11.00	76.97	CARDIAC REHABILITATION	0	2,644	1,206	856	11.00
12.00	65.00	RESPIRATORY THERAPY	0	0	0	51,000	12.00
13.00	76.01	WOUND CARE	0	6,101	8,199	18,599	13.00
14.00	70.01	SLEEP LAB/NEUROLOGY	0	3,254	3,046	-3,724	14.00
15.00	66.00	PHYSICAL THERAPY	0	305	1,445	1,970	15.00
16.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	37,946	16.00
17.00	5.00	DR. AE	0	1,322	778	2,001	17.00
18.00	5.00	DR. AF	0	508	1,592	1,592	18.00
19.00	5.00	DR. AG	0	3,050	1,159	1,159	19.00
200.00			0	161,613	92,123	583,526	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 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	3,002,663	3,002,663			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	3,160,071		3,160,071		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,221,509	0	0	8,221,509	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,205,760	1,125,913	1,184,937	141,838	17,658,448 5.00
6.00 00600	MAINTENANCE & REPAIRS	1,483,084	385,607	405,822	153,680	2,428,193 6.00
7.00 00700	OPERATION OF PLANT	2,149,974	11,858	12,479	273,806	2,448,117 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	390,493	6,705	7,057	15,852	420,107 8.00
9.00 00900	HOUSEKEEPING	1,686,520	29,918	31,486	255,411	2,003,335 9.00
10.00 01000	DIETARY	1,037,561	104,805	110,300	108,271	1,360,937 10.00
11.00 01100	CAFETERIA	694,441	0	0	149,724	844,165 11.00
13.00 01300	NURSING ADMINISTRATION	1,553,803	3,988	4,197	302,457	1,864,445 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,335,173	60,850	64,040	90,085	1,550,148 14.00
15.00 01500	PHARMACY	1,406,846	28,533	30,029	533,637	1,999,045 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,241,372	42,993	45,247	0	1,329,612 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	8,509,980	299,250	314,937	1,908,684	11,032,851 30.00
31.00 03100	INTENSIVE CARE UNIT	1,854,771	65,412	68,841	353,253	2,342,277 31.00
40.00 04000	SUBPROVIDER - I/PF	1,588,857	58,742	61,821	384,066	2,093,486 40.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,247,304	258,118	271,650	942,281	7,719,353 50.00
53.00 05300	ANESTHESIOLOGY	180,027	0	0	368	180,395 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,303,375	105,635	111,172	398,628	2,918,810 54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0 55.00
56.00 05600	RADIOISOTOPE	380,799	11,081	11,662	42,363	445,905 56.00
57.00 05700	CT SCAN	722,184	12,264	12,907	110,440	857,795 57.00
58.00 05800	MRI	270,635	16,287	17,141	48,113	352,176 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	2,099,308	52,072	54,802	0	2,206,182 60.00
65.00 06500	RESPIRATORY THERAPY	874,166	0	0	179,289	1,053,455 65.00
66.00 06600	PHYSICAL THERAPY	267,986	8,170	8,598	66,227	350,981 66.00
67.00 06700	OCCUPATIONAL THERAPY	73,550	0	0	18,190	91,740 67.00
68.00 06800	SPEECH PATHOLOGY	106,957	0	0	26,092	133,049 68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0 70.00
70.01 07001	SLEEP LAB/NEUROLOGY	962,383	27,236	28,664	189,120	1,207,403 70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,867,220	0	0	0	3,867,220 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,413,661	0	0	0	1,413,661 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,900,079	0	0	0	5,900,079 73.00
76.00 03951	CARDIOLOGY	68,822	68,782	72,388	13,466	223,458 76.00
76.01 03950	WOUND CARE	1,408,479	0	0	150,255	1,558,734 76.01
76.97 07697	CARDIAC REHABILITATION	300,377	28,771	30,279	71,029	430,456 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	363,400	0	0	54,509	417,909 76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	WOMENS CENTER	0	0	0	0	0 90.01
90.02 09002	PSYCH SERVICES	0	0	0	0	0 90.02
90.03 09003	OP BEHAVIORAL HEALTH	799,667	62,492	65,767	190,453	1,118,379 90.03
90.04 09004	DIABETES CENTER	0	0	0	0	0 90.04
91.00 09100	EMERGENCY	3,312,292	92,904	97,774	646,665	4,149,635 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	86,445,549	2,968,386	3,123,997	7,818,252	85,971,941 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,988	4,197	0	8,185 190.00
190.02 19002	CRISIS PROGRAM	1,650,868	11,002	11,579	403,257	2,076,706 190.02
191.00 19100	RESEARCH	0	0	0	0	0 191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	19,287	20,298	0	39,585 192.00
200.00	Cross Foot Adjustments	0	0	0	0	0 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	88,096,417	3,002,663	3,160,071	8,221,509	88,096,417 202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/22/2017 12:22 pm	
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	17,658,448					5.00
6.00	00600	MAINTENANCE & REPAIRS	608,736	3,036,929				6.00
7.00	00700	OPERATION OF PLANT	613,731	24,150	3,085,998			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	105,319	13,656	13,988	553,070		8.00
9.00	00900	HOUSEKEEPING	502,226	60,932	62,413	0	2,628,906	9.00
10.00	01000	DIETARY	341,180	213,452	218,639	0	190,983	10.00
11.00	01100	CAFETERIA	211,628	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	467,407	8,122	8,319	0	7,267	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	388,614	123,931	126,943	0	110,886	14.00
15.00	01500	PHARMACY	501,151	58,111	59,523	0	51,994	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333,327	87,562	89,690	0	78,345	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,765,880	609,467	624,280	155,475	545,311	30.00
31.00	03100	INTENSIVE CARE UNIT	587,197	133,221	136,459	24,293	119,198	31.00
40.00	04000	SUBPROVIDER - I/PF	524,826	119,636	122,544	23,136	107,043	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,935,203	525,696	538,472	133,843	470,359	50.00
53.00	05300	ANESTHESIOLOGY	45,224	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	731,731	215,141	220,369	45,694	192,494	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	111,786	22,569	23,117	0	20,193	56.00
57.00	05700	CT SCAN	215,045	24,977	25,584	0	22,348	57.00
58.00	05800	MRI	88,289	33,170	33,977	0	29,679	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	553,079	106,052	108,629	0	94,889	60.00
65.00	06500	RESPIRATORY THERAPY	264,096	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	87,989	16,639	17,044	0	14,888	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,999	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,355	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	302,690	55,470	56,818	0	49,631	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	969,493	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	354,398	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,479,120	0	0	0	0	73.00
76.00	03951	CARDIOLOGY	56,020	140,085	143,489	34,126	125,339	76.00
76.01	03950	WOUND CARE	390,767	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	107,913	58,596	60,020	45,115	52,428	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	104,768	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	280,372	127,273	130,366	0	113,876	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,040,293	189,212	193,810	91,388	169,295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,125,852	2,967,120	3,014,493	553,070	2,566,446	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,052	8,122	8,319	0	7,267	190.00
190.02	19002	CRISIS PROGRAM	520,620	22,407	22,952	0	20,048	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,924	39,280	40,234	0	35,145	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,658,448	3,036,929	3,085,998	553,070	2,628,906	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	2,325,191					10.00
11.00	01100	0	1,055,793				11.00
13.00	01300	0	33,940	2,389,500			13.00
14.00	01400	0	24,464	0	2,324,986		14.00
15.00	01500	0	62,668	0	0	2,732,492	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,687,137	305,764	936,001	0	0	30.00
31.00	03100	202,837	50,965	156,014	0	0	31.00
40.00	04000	435,217	53,300	163,162	0	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	127,942	391,656	0	0	50.00
53.00	05300	0	109	332	0	0	53.00
54.00	05400	0	55,690	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	4,534	0	0	0	56.00
57.00	05700	0	14,744	0	0	0	57.00
58.00	05800	0	5,240	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
65.00	06500	0	27,994	85,696	0	0	65.00
66.00	06600	0	6,598	0	0	0	66.00
67.00	06700	0	2,389	0	0	0	67.00
68.00	06800	0	2,987	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	31,904	97,665	0	0	70.01
71.00	07100	0	0	0	1,702,601	0	71.00
72.00	07200	0	0	0	622,385	0	72.00
73.00	07300	0	0	0	0	2,732,492	73.00
76.00	03951	0	1,901	5,818	0	0	76.00
76.01	03950	0	25,034	76,636	0	0	76.01
76.97	07697	0	9,286	28,427	0	0	76.97
76.98	07698	0	9,015	27,595	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	32,854	100,574	0	0	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	0	104,509	319,924	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		2,325,191	993,831	2,389,500	2,324,986	2,732,492	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.02	19002	0	61,962	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		2,325,191	1,055,793	2,389,500	2,324,986	2,732,492	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,918,536				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	199,715	0	18,861,881	0	18,861,881
31.00	03100	INTENSIVE CARE UNIT	34,350	0	3,786,811	0	3,786,811
40.00	04000	SUBPROVIDER - IPF	39,711	0	3,682,061	0	3,682,061
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	257,359	0	12,099,883	0	12,099,883
53.00	05300	ANESTHESIOLOGY	24,341	0	250,401	0	250,401
54.00	05400	RADIOLOGY-DIAGNOSTIC	131,170	0	4,511,099	0	4,511,099
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	15,802	0	643,906	0	643,906
57.00	05700	CT SCAN	196,737	0	1,357,230	0	1,357,230
58.00	05800	MRI	78,580	0	621,111	0	621,111
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	160,132	0	3,228,963	0	3,228,963
65.00	06500	RESPIRATORY THERAPY	24,619	0	1,455,860	0	1,455,860
66.00	06600	PHYSICAL THERAPY	5,703	0	499,842	0	499,842
67.00	06700	OCCUPATIONAL THERAPY	2,778	0	119,906	0	119,906
68.00	06800	SPEECH PATHOLOGY	1,506	0	170,897	0	170,897
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01	07001	SLEEP LAB/NEUROLOGY	55,137	0	1,856,718	0	1,856,718
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	63,100	0	6,602,414	0	6,602,414
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,814	0	2,426,258	0	2,426,258
73.00	07300	DRUGS CHARGED TO PATIENTS	158,865	0	10,270,556	0	10,270,556
76.00	03951	CARDIOLOGY	4,330	0	734,566	0	734,566
76.01	03950	WOUND CARE	57,114	0	2,108,285	0	2,108,285
76.97	07697	CARDIAC REHABILITATION	6,713	0	798,954	0	798,954
76.98	07698	HYPERBARIC OXYGEN THERAPY	14,190	0	573,477	0	573,477
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WOMENS CENTER	0	0	0	0	0
90.02	09002	PSYCH SERVICES	0	0	0	0	0
90.03	09003	OP BEHAVIORAL HEALTH	51,191	0	1,954,885	0	1,954,885
90.04	09004	DIABETES CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	299,579	0	6,557,645	0	6,557,645
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,918,536	0	85,173,609	0	85,173,609
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	33,945	0	33,945
190.02	19002	CRISIS PROGRAM	0	0	2,724,695	0	2,724,695
191.00	19100	RESEARCH	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	164,168	0	164,168
200.00		Cross Foot Adjustments			0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	1,918,536	0	88,096,417	0	88,096,417

COST ALLOCATION STATISTICS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet Non-CMS W
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	FTE	11.00
13.00	NURSING ADMINISTRATION	13	NURSING HOURS/FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS	14.00
15.00	PHARMACY	15	COSTED REQUIS	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	16	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/22/2017 12:22 pm

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	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	403,611	1,125,913	1,184,937	2,714,461	5.00
6.00 00600	MAINTENANCE & REPAIRS	17,684	385,607	405,822	809,113	6.00
7.00 00700	OPERATION OF PLANT	6,516	11,858	12,479	30,853	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	6,705	7,057	13,762	8.00
9.00 00900	HOUSEKEEPING	0	29,918	31,486	61,404	9.00
10.00 01000	DIETARY	1,518	104,805	110,300	216,623	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	-8,442	3,988	4,197	-257	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	429,610	60,850	64,040	554,500	14.00
15.00 01500	PHARMACY	386,060	28,533	30,029	444,622	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	42,993	45,247	88,240	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	482	299,250	314,937	614,669	30.00
31.00 03100	INTENSIVE CARE UNIT	14,097	65,412	68,841	148,350	31.00
40.00 04000	SUBPROVIDER - IPF	0	58,742	61,821	120,563	40.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	155,468	258,118	271,650	685,236	50.00
53.00 05300	ANESTHESIOLOGY	25	0	0	25	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,988	105,635	111,172	220,795	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	11,081	11,662	22,743	56.00
57.00 05700	CT SCAN	456	12,264	12,907	25,627	57.00
58.00 05800	MRI	0	16,287	17,141	33,428	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	5,618	52,072	54,802	112,492	60.00
65.00 06500	RESPIRATORY THERAPY	3,710	0	0	3,710	65.00
66.00 06600	PHYSICAL THERAPY	0	8,170	8,598	16,768	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	456	0	0	456	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	112,055	27,236	28,664	167,955	70.01
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
76.00 03951	CARDIOLOGY	0	68,782	72,388	141,170	76.00
76.01 03950	WOUND CARE	114,721	0	0	114,721	76.01
76.97 07697	CARDIAC REHABILITATION	490	28,771	30,279	59,540	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	32,318	0	0	32,318	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOMENS CENTER	0	0	0	0	90.01
90.02 09002	PSYCH SERVICES	0	0	0	0	90.02
90.03 09003	OP BEHAVIORAL HEALTH	0	62,492	65,767	128,259	90.03
90.04 09004	DIABETES CENTER	0	0	0	0	90.04
91.00 09100	EMERGENCY	23,717	92,904	97,774	214,395	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,704,158	2,968,386	3,123,997	7,796,541	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,988	4,197	8,185	190.00
190.02 19002	CRISIS PRGRAM	0	11,002	11,579	22,581	190.02
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	19,287	20,298	39,585	192.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,704,158	3,002,663	3,160,071	7,866,892	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0176

Period: From 07/01/2016 To 06/30/2017

Worksheet B Part II Date/Time Prepared: 11/22/2017 12:22 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	2,714,461					5.00
6.00	00600	93,575	902,688				6.00
7.00	00700	94,343	7,178	132,374			7.00
8.00	00800	16,190	4,059	600	34,611		8.00
9.00	00900	77,203	18,111	2,677	0	159,395	9.00
10.00	01000	52,446	63,446	9,379	0	11,580	10.00
11.00	01100	32,532	0	0	0	0	11.00
13.00	01300	71,850	2,414	357	0	441	13.00
14.00	01400	59,738	36,837	5,445	0	6,723	14.00
15.00	01500	77,037	17,273	2,553	0	3,152	15.00
16.00	01600	51,239	26,027	3,847	0	4,750	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	425,168	181,158	26,778	9,729	33,063	30.00
31.00	03100	90,264	39,598	5,853	1,520	7,227	31.00
40.00	04000	80,677	35,560	5,257	1,448	6,490	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	297,481	156,256	23,098	8,376	28,519	50.00
53.00	05300	6,952	0	0	0	0	53.00
54.00	05400	112,482	63,948	9,453	2,860	11,671	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	17,184	6,708	992	0	1,224	56.00
57.00	05700	33,057	7,424	1,097	0	1,355	57.00
58.00	05800	13,572	9,859	1,457	0	1,799	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	85,020	31,523	4,660	0	5,753	60.00
65.00	06500	40,597	0	0	0	0	65.00
66.00	06600	13,526	4,946	731	0	903	66.00
67.00	06700	3,535	0	0	0	0	67.00
68.00	06800	5,127	0	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	46,530	16,488	2,437	0	3,009	70.01
71.00	07100	149,031	0	0	0	0	71.00
72.00	07200	54,478	0	0	0	0	72.00
73.00	07300	227,371	0	0	0	0	73.00
76.00	03951	8,611	41,638	6,155	2,136	7,600	76.00
76.01	03950	60,069	0	0	0	0	76.01
76.97	07697	16,588	17,417	2,575	2,823	3,179	76.97
76.98	07698	16,105	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	43,099	37,830	5,592	0	6,904	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	159,914	56,241	8,313	5,719	10,265	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		2,632,591	881,939	129,306	34,611	155,607	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	315	2,414	357	0	441	190.00
190.02	19002	80,030	6,660	985	0	1,216	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	1,525	11,675	1,726	0	2,131	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,714,461	902,688	132,374	34,611	159,395	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	353,474					10.00
11.00	01100	0	32,532				11.00
13.00	01300	0	1,046	75,851			13.00
14.00	01400	0	754	0	663,997		14.00
15.00	01500	0	1,931	0	0	546,568	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	256,478	9,423	29,711	0	0	30.00
31.00	03100	30,835	1,570	4,952	0	0	31.00
40.00	04000	66,161	1,642	5,179	0	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	3,942	12,433	0	0	50.00
53.00	05300	0	3	11	0	0	53.00
54.00	05400	0	1,716	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	140	0	0	0	56.00
57.00	05700	0	454	0	0	0	57.00
58.00	05800	0	161	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
65.00	06500	0	863	2,720	0	0	65.00
66.00	06600	0	203	0	0	0	66.00
67.00	06700	0	74	0	0	0	67.00
68.00	06800	0	92	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	983	3,100	0	0	70.01
71.00	07100	0	0	0	486,249	0	71.00
72.00	07200	0	0	0	177,748	0	72.00
73.00	07300	0	0	0	0	546,568	73.00
76.00	03951	0	59	185	0	0	76.00
76.01	03950	0	771	2,433	0	0	76.01
76.97	07697	0	286	902	0	0	76.97
76.98	07698	0	278	876	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	1,012	3,193	0	0	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	0	3,220	10,156	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		353,474	30,623	75,851	663,997	546,568	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.02	19002	0	1,909	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		353,474	32,532	75,851	663,997	546,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/22/2017 12:22 pm		
Cost Center	Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	174,103				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,132	0	1,604,309	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,119	0	333,288	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,605	0	326,582	0	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,366	0	1,238,707	0	50.00
53.00	05300	ANESTHESIOLOGY	2,210	0	9,201	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,909	0	434,834	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	1,435	0	50,426	0	56.00
57.00	05700	CT SCAN	17,862	0	86,876	0	57.00
58.00	05800	MRI	7,134	0	67,410	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	14,539	0	253,987	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,235	0	50,125	0	65.00
66.00	06600	PHYSICAL THERAPY	518	0	37,595	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	252	0	3,861	0	67.00
68.00	06800	SPEECH PATHOLOGY	137	0	5,812	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	5,006	0	245,508	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,729	0	641,009	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,252	0	235,478	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,424	0	788,363	0	73.00
76.00	03951	CARDIOLOGY	393	0	207,947	0	76.00
76.01	03950	WOUND CARE	5,186	0	183,180	0	76.01
76.97	07697	CARDIAC REHABILITATION	609	0	103,919	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,288	0	50,865	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	4,648	0	230,537	0	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	27,115	0	495,338	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	174,103	0	7,685,157	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	11,712	0	190.00
190.02	19002	CRISIS PROGRAM	0	0	113,381	0	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	56,642	0	192.00
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 118-201)	174,103	0	7,866,892	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT	340,332					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		340,332				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	32,854,653			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	127,615	127,615	566,812	-17,658,448	70,437,969	5.00
6.00 00600	MAINTENANCE & REPAIRS	43,706	43,706	614,132	0	2,428,193	6.00
7.00 00700	OPERATION OF PLANT	1,344	1,344	1,094,178	0	2,448,117	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	760	760	63,348	0	420,107	8.00
9.00 00900	HOUSEKEEPING	3,391	3,391	1,020,668	0	2,003,935	9.00
10.00 01000	DIETARY	11,879	11,879	432,672	0	1,360,937	10.00
11.00 01100	CAFETERIA	0	0	598,325	0	844,165	11.00
13.00 01300	NURSING ADMINISTRATION	452	452	1,208,674	0	1,864,445	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,897	6,897	359,995	0	1,550,148	14.00
15.00 01500	PHARMACY	3,234	3,234	2,132,510	0	1,999,045	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,873	4,873	0	0	1,329,612	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	33,918	33,918	7,627,471	0	11,032,851	30.00
31.00 03100	INTENSIVE CARE UNIT	7,414	7,414	1,411,662	0	2,342,277	31.00
40.00 04000	SUBPROVIDER - IPF	6,658	6,658	1,534,798	0	2,093,486	40.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	29,256	29,256	3,765,525	0	7,719,353	50.00
53.00 05300	ANESTHESIOLOGY	0	0	1,472	0	180,395	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	11,973	11,973	1,592,990	0	2,918,810	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	1,256	1,256	169,289	0	445,905	56.00
57.00 05700	CT SCAN	1,390	1,390	441,337	0	857,795	57.00
58.00 05800	MRI	1,846	1,846	192,269	0	352,176	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	5,902	5,902	0	0	2,206,182	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	716,470	0	1,053,455	65.00
66.00 06600	PHYSICAL THERAPY	926	926	264,653	0	350,981	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	72,690	0	91,740	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	104,268	0	133,049	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	3,087	3,087	755,758	0	1,207,403	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,867,220	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,413,661	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,900,079	73.00
76.00 03951	CARDIOLOGY	7,796	7,796	53,811	0	223,458	76.00
76.01 03950	WOUND CARE	0	0	600,447	0	1,558,734	76.01
76.97 07697	CARDIAC REHABILITATION	3,261	3,261	283,846	0	430,456	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	217,826	0	417,909	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
90.01 09001	WOMENS CENTER	0	0	0	0	0	90.01
90.02 09002	PSYCH SERVICES	0	0	0	0	0	90.02
90.03 09003	OP BEHAVIORAL HEALTH	7,083	7,083	761,083	0	1,118,379	90.03
90.04 09004	DIABETES CENTER	0	0	0	0	0	90.04
91.00 09100	EMERGENCY	10,530	10,530	2,584,188	0	4,149,635	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	336,447	336,447	31,243,167	-17,658,448	68,313,493	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	452	452	0	0	8,185	190.00
190.02 19002	CRISIS PROGRAM	1,247	1,247	1,611,486	0	2,076,706	190.02
191.00 19100	RESEARCH	0	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,186	2,186	0	0	39,585	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,002,663	3,160,071	8,221,509		17,658,448	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.822747	9.285260	0.250239		0.250695	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		2,714,461	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.038537	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	169,011					6.00
7.00	00700	1,344	167,667				7.00
8.00	00800	760	760	544,744			8.00
9.00	00900	3,391	3,391	0	163,516		9.00
10.00	01000	11,879	11,879	0	11,879	150,250	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	452	452	0	452	0	13.00
14.00	01400	6,897	6,897	0	6,897	0	14.00
15.00	01500	3,234	3,234	0	3,234	0	15.00
16.00	01600	4,873	4,873	0	4,873	0	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	33,918	33,918	153,135	33,918	109,020	30.00
31.00	03100	7,414	7,414	23,927	7,414	13,107	31.00
40.00	04000	6,658	6,658	22,788	6,658	28,123	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	29,256	29,256	131,828	29,256	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	11,973	11,973	45,006	11,973	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	1,256	1,256	0	1,256	0	56.00
57.00	05700	1,390	1,390	0	1,390	0	57.00
58.00	05800	1,846	1,846	0	1,846	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	5,902	5,902	0	5,902	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	926	926	0	926	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	3,087	3,087	0	3,087	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03951	7,796	7,796	33,612	7,796	0	76.00
76.01	03950	0	0	0	0	0	76.01
76.97	07697	3,261	3,261	44,436	3,261	0	76.97
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	7,083	7,083	0	7,083	0	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	10,530	10,530	90,012	10,530	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		165,126	163,782	544,744	159,631	150,250	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	452	452	0	452	0	190.00
190.02	19002	1,247	1,247	0	1,247	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	2,186	2,186	0	2,186	0	192.00
200.00							200.00
201.00							201.00
202.00		3,036,929	3,085,998	553,070	2,628,906	2,325,191	202.00
203.00		17.968825	18.405518	1.015284	16.077362	15.475481	203.00
204.00		902,688	132,374	34,611	159,395	353,474	204.00
205.00		5.341001	0.789505	0.063536	0.974798	2.352572	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING HOURS/FTEs)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		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
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	38,884					11.00
13.00	01300	1,250	28,748				13.00
14.00	01400	901	0	5,280,881			14.00
15.00	01500	2,308	0	0	5,900,079		15.00
16.00	01600	0	0	0	0	309,413,846	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	11,261	11,261	0	0	32,206,843	30.00
31.00	03100	1,877	1,877	0	0	5,539,462	31.00
40.00	04000	1,963	1,963	0	0	6,403,959	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,712	4,712	0	0	41,502,743	50.00
53.00	05300	4	4	0	0	3,925,405	53.00
54.00	05400	2,051	0	0	0	21,153,077	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	167	0	0	0	2,548,254	56.00
57.00	05700	543	0	0	0	31,726,617	57.00
58.00	05800	193	0	0	0	12,672,183	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	25,823,505	60.00
65.00	06500	1,031	1,031	0	0	3,970,241	65.00
66.00	06600	243	0	0	0	919,713	66.00
67.00	06700	88	0	0	0	448,017	67.00
68.00	06800	110	0	0	0	242,816	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	1,175	1,175	0	0	8,891,588	70.01
71.00	07100	0	0	3,867,220	0	10,175,712	71.00
72.00	07200	0	0	1,413,661	0	5,775,459	72.00
73.00	07300	0	0	0	5,900,079	25,619,216	73.00
76.00	03951	70	70	0	0	698,253	76.00
76.01	03950	922	922	0	0	9,210,493	76.01
76.97	07697	342	342	0	0	1,082,564	76.97
76.98	07698	332	332	0	0	2,288,329	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	1,210	1,210	0	0	8,255,248	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	3,849	3,849	0	0	48,334,149	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		36,602	28,748	5,280,881	5,900,079	309,413,846	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.02	19002	2,282	0	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		1,055,793	2,389,500	2,324,986	2,732,492	1,918,536	202.00
203.00		27.152376	83.118826	0.440265	0.463128	0.006201	203.00
204.00		32,532	75,851	663,997	546,568	174,103	204.00
205.00		0.836642	2.638479	0.125736	0.092637	0.000563	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL 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
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
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	70.01
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
76.00	03951	CARDIOLOGY	76.00
76.01	03950	WOUND CARE	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	WOMENS CENTER	90.01
90.02	09002	PSYCH SERVICES	90.02
90.03	09003	OP BEHAVIORAL HEALTH	90.03
90.04	09004	DIABETES CENTER	90.04
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.02	19002	CRISIS PROGRAM	190.02
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,861,881		18,861,881	0	18,861,881	30.00
31.00	03100	INTENSIVE CARE UNIT	3,786,811		3,786,811	20,014	3,806,825	31.00
40.00	04000	SUBPROVIDER - I/PF	3,682,061		3,682,061	0	3,682,061	40.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,099,883		12,099,883	27,284	12,127,167	50.00
53.00	05300	ANESTHESIOLOGY	250,401		250,401	3,622	254,023	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,511,099		4,511,099	14,379	4,525,478	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	643,906		643,906	0	643,906	56.00
57.00	05700	CT SCAN	1,357,230		1,357,230	0	1,357,230	57.00
58.00	05800	MRI	621,111		621,111	0	621,111	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	3,228,963		3,228,963	0	3,228,963	60.00
65.00	06500	RESPIRATORY THERAPY	1,455,860	0	1,455,860	0	1,455,860	65.00
66.00	06600	PHYSICAL THERAPY	499,842	0	499,842	1,445	501,287	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,906	0	119,906	0	119,906	67.00
68.00	06800	SPEECH PATHOLOGY	170,897	0	170,897	0	170,897	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	1,856,718		1,856,718	3,046	1,859,764	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,602,414		6,602,414	0	6,602,414	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,426,258		2,426,258	0	2,426,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,270,556		10,270,556	0	10,270,556	73.00
76.00	03951	CARDIOLOGY	734,566		734,566	0	734,566	76.00
76.01	03950	WOUND CARE	2,108,285		2,108,285	8,199	2,116,484	76.01
76.97	07697	CARDIAC REHABILITATION	798,954		798,954	1,206	800,160	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	573,477		573,477	0	573,477	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOMENS CENTER	0		0	0	0	90.01
90.02	09002	PSYCH SERVICES	0		0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	1,954,885		1,954,885	0	1,954,885	90.03
90.04	09004	DIABETES CENTER	0		0	0	0	90.04
91.00	09100	EMERGENCY	6,557,645		6,557,645	9,399	6,567,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,676,006		1,676,006	0	1,676,006	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	86,849,615	0	86,849,615	88,594	86,938,209	200.00
201.00		Less Observation Beds	1,676,006		1,676,006		1,676,006	201.00
202.00		Total (see instructions)	85,173,609	0	85,173,609	88,594	85,262,203	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	29,103,083		29,103,083			30.00
31.00 03100 INTENSIVE CARE UNIT	5,539,462		5,539,462			31.00
40.00 04000 SUBPROVIDER - IPF	6,403,959		6,403,959			40.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	9,411,980	32,090,763	41,502,743	0.291544	0.000000	50.00
53.00 05300 ANESTHESIOLOGY	1,193,454	2,731,951	3,925,405	0.063790	0.000000	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	4,579,067	16,574,010	21,153,077	0.213260	0.000000	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00 05600 RADIOISOTOPE	554,352	1,993,902	2,548,254	0.252685	0.000000	56.00
57.00 05700 CT SCAN	7,030,658	24,695,959	31,726,617	0.042779	0.000000	57.00
58.00 05800 MRI	1,169,629	11,502,554	12,672,183	0.049014	0.000000	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00 06000 LABORATORY	12,511,234	13,312,271	25,823,505	0.125040	0.000000	60.00
65.00 06500 RESPIRATORY THERAPY	3,370,300	599,941	3,970,241	0.366693	0.000000	65.00
66.00 06600 PHYSICAL THERAPY	841,632	78,081	919,713	0.543476	0.000000	66.00
67.00 06700 OCCUPATIONAL THERAPY	415,162	32,855	448,017	0.267637	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	232,448	10,368	242,816	0.703813	0.000000	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	61,620	8,829,968	8,891,588	0.208817	0.000000	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,692,692	4,483,020	10,175,712	0.648840	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3,230,324	2,545,135	5,775,459	0.420098	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	11,905,957	13,713,259	25,619,216	0.400893	0.000000	73.00
76.00 03951 CARDIOLOGY	159,191	539,062	698,253	1.052006	0.000000	76.00
76.01 03950 WOUND CARE	12,733	9,197,760	9,210,493	0.228900	0.000000	76.01
76.97 07697 CARDIAC REHABILITATION	494	1,082,070	1,082,564	0.738020	0.000000	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	5,530	2,282,799	2,288,329	0.250610	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0.000000	0.000000	90.00
90.01 09001 WOMENS CENTER	0	0	0	0.000000	0.000000	90.01
90.02 09002 PSYCH SERVICES	0	0	0	0.000000	0.000000	90.02
90.03 09003 OP BEHAVIORAL HEALTH	10,785	8,244,463	8,255,248	0.236805	0.000000	90.03
90.04 09004 DIABETES CENTER	0	0	0	0.000000	0.000000	90.04
91.00 09100 EMERGENCY	11,290,796	37,043,353	48,334,149	0.135673	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3,103,760	3,103,760	0.539992	0.000000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	114,726,542	194,687,304	309,413,846		200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)	114,726,542	194,687,304	309,413,846		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.292202	50.00
53.00	05300	ANESTHESIOLOGY	0.064713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213939	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.252685	56.00
57.00	05700	CT SCAN	0.042779	57.00
58.00	05800	MRI	0.049014	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.125040	60.00
65.00	06500	RESPIRATORY THERAPY	0.366693	65.00
66.00	06600	PHYSICAL THERAPY	0.545047	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267637	67.00
68.00	06800	SPEECH PATHOLOGY	0.703813	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.209160	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.648840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.420098	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.400893	73.00
76.00	03951	CARDIOLOGY	1.052006	76.00
76.01	03950	WOUND CARE	0.229791	76.01
76.97	07697	CARDIAC REHABILITATION	0.739134	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.250610	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOMENS CENTER	0.000000	90.01
90.02	09002	PSYCH SERVICES	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.236805	90.03
90.04	09004	DIABETES CENTER	0.000000	90.04
91.00	09100	EMERGENCY	0.135868	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.539992	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/22/2017 12:22 pm	
		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		18,861,881		0	18,861,881	30.00
31.00	03100 INTENSIVE CARE UNIT		3,786,811		20,014	3,806,825	31.00
40.00	04000 SUBPROVIDER - I/PF		3,682,061		0	3,682,061	40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		12,099,883		27,284	12,127,167	50.00
53.00	05300 ANESTHESIOLOGY		250,401		3,622	254,023	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,511,099		14,379	4,525,478	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC		0		0	0	55.00
56.00	05600 RADIOISOTOPE		643,906		0	643,906	56.00
57.00	05700 CT SCAN		1,357,230		0	1,357,230	57.00
58.00	05800 MRI		621,111		0	621,111	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	0	59.00
60.00	06000 LABORATORY		3,228,963		0	3,228,963	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,455,860		0	1,455,860	65.00
66.00	06600 PHYSICAL THERAPY	0	499,842		1,445	501,287	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	119,906		0	119,906	67.00
68.00	06800 SPEECH PATHOLOGY	0	170,897		0	170,897	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY		1,856,718		3,046	1,859,764	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		6,602,414		0	6,602,414	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		2,426,258		0	2,426,258	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		10,270,556		0	10,270,556	73.00
76.00	03951 CARDIOLOGY		734,566		0	734,566	76.00
76.01	03950 WOUND CARE		2,108,285		8,199	2,116,484	76.01
76.97	07697 CARDIAC REHABILITATION		798,954		1,206	800,160	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		573,477		0	573,477	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		0		0	0	90.00
90.01	09001 WOMENS CENTER		0		0	0	90.01
90.02	09002 PSYCH SERVICES		0		0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH		1,954,885		0	1,954,885	90.03
90.04	09004 DIABETES CENTER		0		0	0	90.04
91.00	09100 EMERGENCY		6,557,645		9,399	6,567,044	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,676,006		0	1,676,006	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)		86,849,615	0	88,594	86,938,209	200.00
201.00	Less Observation Beds		1,676,006			1,676,006	201.00
202.00	Total (see instructions)		85,173,609	0	88,594	85,262,203	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	29,103,083		29,103,083		30.00
31.00	03100	INTENSIVE CARE UNIT	5,539,462		5,539,462		31.00
40.00	04000	SUBPROVIDER - IPF	6,403,959		6,403,959		40.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,411,980	32,090,763	41,502,743	0.291544	50.00
53.00	05300	ANESTHESIOLOGY	1,193,454	2,731,951	3,925,405	0.063790	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,579,067	16,574,010	21,153,077	0.213260	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	554,352	1,993,902	2,548,254	0.252685	56.00
57.00	05700	CT SCAN	7,030,658	24,695,959	31,726,617	0.042779	57.00
58.00	05800	MRI	1,169,629	11,502,554	12,672,183	0.049014	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	12,511,234	13,312,271	25,823,505	0.125040	60.00
65.00	06500	RESPIRATORY THERAPY	3,370,300	599,941	3,970,241	0.366693	65.00
66.00	06600	PHYSICAL THERAPY	841,632	78,081	919,713	0.543476	66.00
67.00	06700	OCCUPATIONAL THERAPY	415,162	32,855	448,017	0.267637	67.00
68.00	06800	SPEECH PATHOLOGY	232,448	10,368	242,816	0.703813	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	61,620	8,829,968	8,891,588	0.208817	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,692,692	4,483,020	10,175,712	0.648840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,230,324	2,545,135	5,775,459	0.420098	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,905,957	13,713,259	25,619,216	0.400893	73.00
76.00	03951	CARDIOLOGY	159,191	539,062	698,253	1.052006	76.00
76.01	03950	WOUND CARE	12,733	9,197,760	9,210,493	0.228900	76.01
76.97	07697	CARDIAC REHABILITATION	494	1,082,070	1,082,564	0.738020	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	5,530	2,282,799	2,288,329	0.250610	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOMENS CENTER	0	0	0	0.000000	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	10,785	8,244,463	8,255,248	0.236805	90.03
90.04	09004	DIABETES CENTER	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	11,290,796	37,043,353	48,334,149	0.135673	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,103,760	3,103,760	0.539992	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	114,726,542	194,687,304	309,413,846		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	114,726,542	194,687,304	309,413,846		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/22/2017 12:22 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.000000	70.01
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
76.00	03951	CARDIOLOGY	0.000000	76.00
76.01	03950	WOUND CARE	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOMENS CENTER	0.000000	90.01
90.02	09002	PSYCH SERVICES	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.000000	90.03
90.04	09004	DIABETES CENTER	0.000000	90.04
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part I Date/Time Prepared: 11/22/2017 12:22 pm	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,604,309	0	1,604,309	15,857	101.17	30.00
31.00	INTENSIVE CARE UNIT	333,288	0	333,288	1,737	191.88	31.00
40.00	SUBPROVIDER - IPF	326,582	0	326,582	3,727	87.63	40.00
200.00	Total (Lines 30-199)	2,264,179		2,264,179	21,321		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	6,705	678,345				
31.00	INTENSIVE CARE UNIT	1,039	199,363				
40.00	SUBPROVIDER - IPF	829	72,645				
200.00	Total (Lines 30-199)	8,573	950,353				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/22/2017 12:22 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,238,707	41,502,743	0.029846	4,000,440	119,397	50.00
53.00	05300	ANESTHESIOLOGY	9,201	3,925,405	0.002344	449,510	1,054	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	434,834	21,153,077	0.020557	2,649,638	54,469	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	50,426	2,548,254	0.019788	321,258	6,357	56.00
57.00	05700	CT SCAN	86,876	31,726,617	0.002738	3,742,803	10,248	57.00
58.00	05800	MRI	67,410	12,672,183	0.005320	527,240	2,805	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	253,987	25,823,505	0.009835	6,383,253	62,779	60.00
65.00	06500	RESPIRATORY THERAPY	50,125	3,970,241	0.012625	1,996,021	25,200	65.00
66.00	06600	PHYSICAL THERAPY	37,595	919,713	0.040877	593,141	24,246	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,861	448,017	0.008618	291,650	2,513	67.00
68.00	06800	SPEECH PATHOLOGY	5,812	242,816	0.023936	154,517	3,699	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	245,508	8,891,588	0.027611	44,807	1,237	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	641,009	10,175,712	0.062994	1,771,608	111,601	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	235,478	5,775,459	0.040772	1,298,756	52,953	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	788,363	25,619,216	0.030772	5,833,322	179,503	73.00
76.00	03951	CARDIOLOGY	207,947	698,253	0.297810	92,754	27,623	76.00
76.01	03950	WOUND CARE	183,180	9,210,493	0.019888	12,733	253	76.01
76.97	07697	CARDIAC REHABILITATION	103,919	1,082,564	0.095993	494	47	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	50,865	2,288,329	0.022228	5,530	123	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0.000000	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0.000000	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	230,537	8,255,248	0.027926	10,785	301	90.03
90.04	09004	DIABETES CENTER	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	495,338	48,334,149	0.010248	5,508,096	56,447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	142,554	3,103,760	0.045929	0	0	92.00
200.00		Total (lines 50-199)	5,563,532	268,367,342		35,688,356	742,855	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part III Date/Time Prepared: 11/22/2017 12:22 pm
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Cost Center Description			Title XVIII				Hospital	PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
			1.00	2.00	3.00	4.00	5.00		
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	
200.00		Total (lines 30-199)	0	0	0	0	0	200.00	
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School		
			6.00	7.00	8.00	9.00	11.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	15,857	0.00	6,705	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	1,737	0.00	1,039	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	3,727	0.00	829	0	0	40.00	
200.00		Total (lines 30-199)	21,321		8,573	0	0	200.00	
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost					
			12.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0	0					31.00
40.00	04000	SUBPROVIDER - IPF	0	0					40.00
200.00		Total (lines 30-199)	0	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part IV
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		Title XVIII			Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	70.01
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
76.00	03951	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0	0	0	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part IV
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description			Title XVIII			Hospital		PPS
			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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	41,502,743	0.000000	0.000000	4,000,440	50.00
53.00	05300	ANESTHESIOLOGY	0	3,925,405	0.000000	0.000000	449,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,153,077	0.000000	0.000000	2,649,638	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0	2,548,254	0.000000	0.000000	321,258	56.00
57.00	05700	CT SCAN	0	31,726,617	0.000000	0.000000	3,742,803	57.00
58.00	05800	MRI	0	12,672,183	0.000000	0.000000	527,240	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	25,823,505	0.000000	0.000000	6,383,253	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,970,241	0.000000	0.000000	1,996,021	65.00
66.00	06600	PHYSICAL THERAPY	0	919,713	0.000000	0.000000	593,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	448,017	0.000000	0.000000	291,650	67.00
68.00	06800	SPEECH PATHOLOGY	0	242,816	0.000000	0.000000	154,517	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	8,891,588	0.000000	0.000000	44,807	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,175,712	0.000000	0.000000	1,771,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,775,459	0.000000	0.000000	1,298,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,619,216	0.000000	0.000000	5,833,322	73.00
76.00	03951	CARDIOLOGY	0	698,253	0.000000	0.000000	92,754	76.00
76.01	03950	WOUND CARE	0	9,210,493	0.000000	0.000000	12,733	76.01
76.97	07697	CARDIAC REHABILITATION	0	1,082,564	0.000000	0.000000	494	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	2,288,329	0.000000	0.000000	5,530	76.98
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOMENS CENTER	0	0	0.000000	0.000000	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0.000000	0.000000	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	8,255,248	0.000000	0.000000	10,785	90.03
90.04	09004	DIABETES CENTER	0	0	0.000000	0.000000	0	90.04
91.00	09100	EMERGENCY	0	48,334,149	0.000000	0.000000	5,508,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,103,760	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	268,367,342			35,688,356	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 12:22 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	10,257,270	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	665,004	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,924,380	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	693,650	0	0	0	56.00
57.00	05700 CT SCAN	0	7,253,076	0	0	0	57.00
58.00	05800 MRI	0	3,650,541	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	3,485,247	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	211,213	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	32,768	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	11,903	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	3,975	0	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	2,609,352	0	0	0	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,115,466	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	638,066	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,621,796	0	0	0	73.00
76.00	03951 CARDIOLOGY	0	176,136	0	0	0	76.00
76.01	03950 WOUND CARE	0	4,455,346	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	585,472	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	772,914	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	1,106,651	0	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100 EMERGENCY	0	7,201,466	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,064,321	0	0	0	92.00
200.00	Total (lines 50-199)	0	56,536,013	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part IV
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0		70.01
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	0		73.00
76.00	03951	CARDIOLOGY	0	0		76.00
76.01	03950	WOUND CARE	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0		76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOMENS CENTER	0	0		90.01
90.02	09002	PSYCH SERVICES	0	0		90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0		90.03
90.04	09004	DIABETES CENTER	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Total (Lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.291544	10,257,270	0	0	2,990,446	50.00
53.00 05300 ANESTHESIOLOGY	0.063790	665,004	0	0	42,421	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.213260	3,924,380	0	0	836,913	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.252685	693,650	0	0	175,275	56.00
57.00 05700 CT SCAN	0.042779	7,253,076	0	0	310,279	57.00
58.00 05800 MRI	0.049014	3,650,541	0	0	178,928	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.125040	3,485,247	0	0	435,795	60.00
65.00 06500 RESPIRATORY THERAPY	0.366693	211,213	0	0	77,450	65.00
66.00 06600 PHYSICAL THERAPY	0.543476	32,768	0	0	17,809	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.267637	11,903	0	0	3,186	67.00
68.00 06800 SPEECH PATHOLOGY	0.703813	3,975	0	0	2,798	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0.208817	2,609,352	0	0	544,877	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.648840	1,115,466	0	0	723,759	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.420098	638,066	0	0	268,050	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.400893	6,621,796	0	20,668	2,654,632	73.00
76.00 03951 RADIOLOGY	1.052006	176,136	0	0	185,296	76.00
76.01 03950 WOUND CARE	0.228900	4,455,346	0	0	1,019,829	76.01
76.97 07697 CARDIAC REHABILITATION	0.738020	585,472	0	0	432,090	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.250610	772,914	0	0	193,700	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 WOMENS CENTER	0.000000	0	0	0	0	90.01
90.02 09002 PSYCH SERVICES	0.000000	0	0	0	0	90.02
90.03 09003 OP BEHAVIORAL HEALTH	0.236805	1,106,651	0	0	262,060	90.03
90.04 09004 DIABETES CENTER	0.000000	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.135673	7,201,466	0	0	977,044	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.539992	1,064,321	0	0	574,725	92.00
200.00	Subtotal (see instructions)	56,536,013	0	20,668	12,907,362	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	56,536,013	0	20,668	12,907,362	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	70.01
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	8,286	73.00
76.00	03951	CARDIOLOGY	0	0	76.00
76.01	03950	WOUND CARE	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0	90.03
90.04	09004	DIABETES CENTER	0	0	90.04
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	8,286	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	8,286	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/22/2017 12:22 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,238,707	41,502,743	0.029846	230	7	50.00
53.00	05300 ANESTHESIOLOGY	9,201	3,925,405	0.002344	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	434,834	21,153,077	0.020557	2,252	46	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	50,426	2,548,254	0.019788	0	0	56.00
57.00	05700 CT SCAN	86,876	31,726,617	0.002738	27,902	76	57.00
58.00	05800 MRI	67,410	12,672,183	0.005320	8,889	47	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	253,987	25,823,505	0.009835	157,346	1,547	60.00
65.00	06500 RESPIRATORY THERAPY	50,125	3,970,241	0.012625	5,230	66	65.00
66.00	06600 PHYSICAL THERAPY	37,595	919,713	0.040877	2,235	91	66.00
67.00	06700 OCCUPATIONAL THERAPY	3,861	448,017	0.008618	667	6	67.00
68.00	06800 SPEECH PATHOLOGY	5,812	242,816	0.023936	1,630	39	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	245,508	8,891,588	0.027611	790	22	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	641,009	10,175,712	0.062994	875	55	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	235,478	5,775,459	0.040772	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	788,363	25,619,216	0.030772	202,494	6,231	73.00
76.00	03951 RADIOLOGY	207,947	698,253	0.297810	0	0	76.00
76.01	03950 WOUND CARE	183,180	9,210,493	0.019888	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	103,919	1,082,564	0.095993	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	50,865	2,288,329	0.022228	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	0.000000	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	0.000000	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	230,537	8,255,248	0.027926	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	0.000000	0	0	90.04
91.00	09100 EMERGENCY	495,338	48,334,149	0.010248	146,988	1,506	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,103,760	0.000000	0	0	92.00
200.00	Total (lines 50-199)	5,420,978	268,367,342		557,528	9,739	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 12:22 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
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
76.00	03951 CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950 WOUND CARE	0	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	0	0	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	0	0	0	90.04
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 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 12:22 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	41,502,743	0.000000	0.000000	230	50.00
53.00 05300 ANESTHESIOLOGY	0	3,925,405	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	21,153,077	0.000000	0.000000	2,252	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
56.00 05600 RADIOISOTOPE	0	2,548,254	0.000000	0.000000	0	56.00
57.00 05700 CT SCAN	0	31,726,617	0.000000	0.000000	27,902	57.00
58.00 05800 MRI	0	12,672,183	0.000000	0.000000	8,889	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	25,823,505	0.000000	0.000000	157,346	60.00
65.00 06500 RESPIRATORY THERAPY	0	3,970,241	0.000000	0.000000	5,230	65.00
66.00 06600 PHYSICAL THERAPY	0	919,713	0.000000	0.000000	2,235	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	448,017	0.000000	0.000000	667	67.00
68.00 06800 SPEECH PATHOLOGY	0	242,816	0.000000	0.000000	1,630	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	8,891,588	0.000000	0.000000	790	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,175,712	0.000000	0.000000	875	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,775,459	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	25,619,216	0.000000	0.000000	202,494	73.00
76.00 03951 CARDIOLOGY	0	698,253	0.000000	0.000000	0	76.00
76.01 03950 WOUND CARE	0	9,210,493	0.000000	0.000000	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	1,082,564	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	2,288,329	0.000000	0.000000	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 09001 WOMENS CENTER	0	0	0.000000	0.000000	0	90.01
90.02 09002 PSYCH SERVICES	0	0	0.000000	0.000000	0	90.02
90.03 09003 OP BEHAVIORAL HEALTH	0	8,255,248	0.000000	0.000000	0	90.03
90.04 09004 DIABETES CENTER	0	0	0.000000	0.000000	0	90.04
91.00 09100 EMERGENCY	0	48,334,149	0.000000	0.000000	146,988	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,103,760	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	268,367,342			557,528	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 12:22 pm
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	70.01
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
76.00	03951	CARDIOLOGY	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0	0	0	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/22/2017 12:22 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0	70.01
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	0	73.00
76.00	03951 CARDIOLOGY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOMENS CENTER	0	0	90.01
90.02	09002 PSYCH SERVICES	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	0	90.03
90.04	09004 DIABETES CENTER	0	0	90.04
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 12:22 pm
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)		15,857	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,857	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)		14,448	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,705	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)		18,861,881	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)		18,861,881	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)		18,861,881	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,189.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,975,598	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)		7,975,598	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 12:22 pm	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	3,806,825	1,737	2,191.61	1,039	2,277,083	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)				8,968,393	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				19,221,074	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)				877,708	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				742,855	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,620,563	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				17,600,511	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)				1,409	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,189.50	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				1,676,006	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/22/2017 12:22 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,604,309	18,861,881	0.085056	1,676,006	142,554	90.00
91.00	Nursing School cost	0	18,861,881	0.000000	1,676,006	0	91.00
92.00	Allied health cost	0	18,861,881	0.000000	1,676,006	0	92.00
93.00	All other Medical Education	0	18,861,881	0.000000	1,676,006	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,727	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,727	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)		3,727	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)		829	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)		3,682,061	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)		3,682,061	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)		3,682,061	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)		987.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		819,002	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)		819,002	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0176 Component CCN: 14-S176		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/22/2017 12:22 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						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)					128,198	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					947,200	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)					72,645	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					9,739	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					82,384	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					864,816	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: 14-0176 Component CCN: 14-S176		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/22/2017 12:22 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	326,582	3,682,061	0.088695	0	0	90.00
91.00	Nursing School cost	0	3,682,061	0.000000	0	0	91.00
92.00	Allied health cost	0	3,682,061	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,682,061	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/22/2017 12:22 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		14,631,233	30.00
31.00	03100	INTENSIVE CARE UNIT		3,324,587	31.00
40.00	04000	SUBPROVIDER - IPF		27,143	40.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.292202	4,000,440	50.00
53.00	05300	ANESTHESIOLOGY	0.064713	449,510	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.213939	2,649,638	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	55.00
56.00	05600	RADIOISOTOPE	0.252685	321,258	56.00
57.00	05700	CT SCAN	0.042779	3,742,803	57.00
58.00	05800	MRI	0.049014	527,240	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.125040	6,383,253	60.00
65.00	06500	RESPIRATORY THERAPY	0.366693	1,996,021	65.00
66.00	06600	PHYSICAL THERAPY	0.545047	593,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.267637	291,650	67.00
68.00	06800	SPEECH PATHOLOGY	0.703813	154,517	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.209160	44,807	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.648840	1,771,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.420098	1,298,756	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.400893	5,833,322	73.00
76.00	03951	CARDIOLOGY	1.052006	92,754	76.00
76.01	03950	WOUND CARE	0.229791	12,733	76.01
76.97	07697	CARDIAC REHABILITATION	0.739134	494	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.250610	5,530	76.98
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09001	WOMENS CENTER	0.000000	0	90.01
90.02	09002	PSYCH SERVICES	0.000000	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.236805	10,785	90.03
90.04	09004	DIABETES CENTER	0.000000	0	90.04
91.00	09100	EMERGENCY	0.135868	5,508,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.539992	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		35,688,356	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)		35,688,356	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		1,386,559	40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.292202	230	67 50.00
53.00	05300 ANESTHESIOLOGY	0.064713	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.213939	2,252	482 54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0 55.00
56.00	05600 RADIOISOTOPE	0.252685	0	0 56.00
57.00	05700 CT SCAN	0.042779	27,902	1,194 57.00
58.00	05800 MRI	0.049014	8,889	436 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000 LABORATORY	0.125040	157,346	19,675 60.00
65.00	06500 RESPIRATORY THERAPY	0.366693	5,230	1,918 65.00
66.00	06600 PHYSICAL THERAPY	0.545047	2,235	1,218 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.267637	667	179 67.00
68.00	06800 SPEECH PATHOLOGY	0.703813	1,630	1,147 68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0.209160	790	165 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.648840	875	568 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.420098	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.400893	202,494	81,178 73.00
76.00	03951 CARDIOLOGY	1.052006	0	0 76.00
76.01	03950 WOUND CARE	0.229791	0	0 76.01
76.97	07697 CARDIAC REHABILITATION	0.739134	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.250610	0	0 76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000	0	0 90.00
90.01	09001 WOMENS CENTER	0.000000	0	0 90.01
90.02	09002 PSYCH SERVICES	0.000000	0	0 90.02
90.03	09003 OP BEHAVIORAL HEALTH	0.236805	0	0 90.03
90.04	09004 DIABETES CENTER	0.000000	0	0 90.04
91.00	09100 EMERGENCY	0.135868	146,988	19,971 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.539992	0	0 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		557,528	128,198 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		557,528	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		3,076,886	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		9,744,506	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		413,182	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		86.73	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 Section 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 section 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 section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.38	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.92	31.00
32.00	Sum of lines 30 and 31		25.30	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.09	33.00
34.00	Disproportionate share adjustment (see instructions)		323,420	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	726,961	708,684	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	182,733	530,057	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	712,790		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 1/1	On/After 1/1	
		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)	14,270,784		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
		Amount		
		1.00		
49.00	Total payment for inpatient operating costs (see instructions)		14,270,784	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,075,841	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)		15,346,625	59.00
60.00	Primary payer payments		10,718	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		15,335,907	61.00
62.00	Deductibles billed to program beneficiaries		1,539,132	62.00
63.00	Coinurance billed to program beneficiaries		82,432	63.00
64.00	Allowable bad debts (see instructions)		496,957	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		323,022	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		295,825	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		14,037,365	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 DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		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)		9,200	70.93
70.94	HRR adjustment amount (see instructions)		-14,616	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/22/2017 12:22 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			14,031,949	71.00
71.01	Sequestration adjustment (see instructions)			280,639	71.01
72.00	Interim payments			13,529,388	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, 72, and 73)			221,922	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			36,541	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 11/22/2017 12:22 pm	
		PPS					
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.38	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	22.92	0.00			22.92	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	25.30	0.00			22.92	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	86.73	0.00			86.73	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	10.09	0.00			8.12	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,063	0			1,063	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	528	0			528	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	29	0			29	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	2,090	0			2,090	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	3,710	0			3,710	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	16,185	0			16,185	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	16,185	0			16,185	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22.92	0.00			22.92	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0176		Period: From 07/01/2016 To 06/30/2017		Worksheet DSH Date/Time Prepared: 11/22/2017 12:22 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	10.09		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		10.09		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		10.09		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet DSH Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	8.12		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	8.12		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	8.12		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/22/2017 12:22 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,076,886	0	3,076,886		3,076,886	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,744,506	0		9,744,506	9,744,506	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	413,182	0	127,993	285,189	413,182	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		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		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	0.1009	0.1009	0.1009	0.1009		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	323,420	0	77,615	245,805	323,420	11.00
11.01	Uncompensated care payments	36.00	712,790	0	182,733	530,057	712,790	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	14,270,784	0	3,465,227	10,805,557	14,270,784	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	14,270,784	0	3,465,227	10,805,557	14,270,784	15.00
16.00	Payment for inpatient program capital	50.00	1,075,841	0	259,171	816,670	1,075,841	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
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/22/2017 12:22 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	3,724,398	11,622,227	15,346,625	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	1,035,524	0	246,808	788,716	1,035,524	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	40,317	0	12,363	27,954	40,317	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,075,841	0	259,171	816,670	1,075,841	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	0.000000		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				0	0	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: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/22/2017 12:22 pm

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00				1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	3,076,886	3,076,886		1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,744,506		9,744,506	1.02	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	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	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	413,182	127,993	285,189	2.00	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	2.01	
3.00	Operating outlier reconciliation	2.01	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	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	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	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	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	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	9.01	
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1009	0.1009	0.1009	10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	323,420	77,615	245,805	11.00	
11.01	Uncompensated care payments	36.00	712,790	182,733	530,057	11.01	
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	14,270,784	3,465,227	10,805,557	13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,270,784	3,465,227	10,805,557	15.00	
16.00	Payment for inpatient program capital	50.00	1,075,841	259,171	816,670	16.00	
17.00	Special add-on payments for new technologies	54.00	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	17.02	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	18.00	
19.00	SUBTOTAL			3,724,398	11,622,227	15,346,625	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/22/2017 12:22 pm

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,035,524	246,808	788,716	1,035,524	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	40,317	12,363	27,954	40,317	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	1,075,841	259,171	816,670	1,075,841	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	9,200	1,563	7,637	9,200	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	-14,616	0	-14,616	-14,616	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: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		8,286	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		12,907,362	2.00
3.00	PPS payments		10,397,432	3.00
4.00	Outlier payment (see instructions)		23,282	4.00
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 line 3 plus line 4 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)		8,286	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		20,668	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)		20,668	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)		20,668	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		12,382	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) (for CAH see instructions)		8,286	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, 8 and 9)		10,420,714	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)		2,163,915	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)		8,265,085	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)		8,265,085	30.00
31.00	Primary payer payments		896	31.00
32.00	Subtotal (line 30 minus line 31)		8,264,189	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)		418,069	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		271,745	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		293,263	36.00
37.00	Subtotal (see instructions)		8,535,934	37.00
38.00	MSP-LCC reconciliation amount from PS&R		9	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		8,535,925	40.00
40.01	Sequestration adjustment (see instructions)		170,719	40.01
41.00	Interim payments		8,397,755	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-32,549	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2017 12:22 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		13,299,070		8,349,473	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	06/29/2017	254,934	02/14/2017	48,282	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	02/14/2017	24,616		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)		230,318		48,282	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)		13,529,388		8,397,755	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		221,922		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		32,549	6.02	
7.00	Total Medicare program liability (see instructions)		13,751,310		8,365,206	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: 14-0176
Component CCN: 14-S176

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
11/22/2017 12:22 pm
PPS

Title XVIII

Subprovider -
IPF

		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		632,584		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)		632,584		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		103,567		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		736,151		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: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		3,776	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		7,744	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		757	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		16,185	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		309,413,846	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		5,962,005	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		338,151	8.00
9.00	Sequestration adjustment amount (see instructions)		6,763	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		331,388	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		383,992	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		-52,604	32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176 Component CCN: 14-S176	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part II Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			719,888 1.00
2.00	Net IPF PPS Outlier Payments			30,587 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)			10.21099 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)			750,475 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)			750,475 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			750,475 18.00
19.00	Deductibles			64,400 19.00
20.00	Subtotal (line 18 minus line 19)			686,075 20.00
21.00	Coinsurance			40,572 21.00
22.00	Subtotal (line 20 minus line 21)			645,503 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			162,571 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			105,671 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			122,743 25.00
26.00	Subtotal (sum of lines 22 and 24)			751,174 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	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			751,174 31.00
31.01	Sequestration adjustment (see instructions)			15,023 31.01
32.00	Interim payments			632,584 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, 32 and 33)			103,567 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			30,587 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: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet G

Date/Time Prepared:
11/22/2017 12:22 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	-11,000	0	0	0	1.00
2.00	Temporary investments	3,902,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	14,937,000	0	0	0	4.00
5.00	Other receivable	50,671,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,305,000	0	0	0	7.00
8.00	Prepaid expenses	300,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	72,104,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	219,885	0	0	0	12.00
13.00	Land improvements	3,212,830	0	0	0	13.00
14.00	Accumulated depreciation	-2,148,865	0	0	0	14.00
15.00	Buildings	75,758,571	0	0	0	15.00
16.00	Accumulated depreciation	-54,585,200	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	56,956,088	0	0	0	23.00
24.00	Accumulated depreciation	-49,156,915	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	9,336,651	0	0	0	27.00
28.00	Accumulated depreciation	-5,728,045	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,865,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	29,524,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	3,857,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,381,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	139,350,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	753,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	7,736,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	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	4,124,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,613,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	72,421,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	778,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	73,199,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	85,812,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	53,538,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	53,538,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	139,350,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-1

Date/Time Prepared:
11/22/2017 12:22 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		56,184,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-2,401,000			2.00
3.00	Total (sum of line 1 and line 2)		53,783,000		0	3.00
4.00	UNRESTRICTED NET ASSETS RELEASED	153,000		0		4.00
5.00	CHANGES IN UNREALIZED GAINS	2,053,000		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		2,206,000		0	10.00
11.00	Subtotal (line 3 plus line 10)		55,989,000		0	11.00
12.00	CHANGES IN TEMP RESTRICTED ASSETS	258,000		0		12.00
13.00	TRANSFER TO AFFILIATED ORGANIZATION	2,193,000		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		2,451,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		53,538,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	UNRESTRICTED NET ASSETS RELEASED		0			4.00
5.00	CHANGES IN UNREALIZED GAINS		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	CHANGES IN TEMP RESTRICTED ASSETS		0			12.00
13.00	TRANSFER TO AFFILIATED ORGANIZATION		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: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/22/2017 12:22 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	29,103,083		29,103,083	1.00
2.00	SUBPROVIDER - IPF	6,403,959		6,403,959	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)	35,507,042		35,507,042	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,539,462		5,539,462	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)	5,539,462		5,539,462	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	41,046,504		41,046,504	17.00
18.00	Ancillary services	62,378,457	146,295,726	208,674,183	18.00
19.00	Outpatient services	11,301,581	48,391,576	59,693,157	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CRISIS PROGRAM	0	1,705,099	1,705,099	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	114,726,542	196,392,401	311,118,943	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		104,273,624		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)		104,273,624		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0176

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-3

Date/Time Prepared:
11/22/2017 12:22 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	311,118,943	1.00
2.00	Less contractual allowances and discounts on patients' accounts	215,073,838	2.00
3.00	Net patient revenues (line 1 minus line 2)	96,045,105	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	104,273,624	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,228,519	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	-63,778	6.00
7.00	Income from investments	1,790,215	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	4,101,001	24.00
24.01	ROUNDING	81	24.01
25.00	Total other income (sum of lines 6-24)	5,827,519	25.00
26.00	Total (line 5 plus line 25)	-2,401,000	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,401,000	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0176	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/22/2017 12:22 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,035,524	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		40,317	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)		44.34	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)		1,075,841	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