

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: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/21/2017 1:04 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: 11/21/2017 Time: 1:04 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 ELMHURST MEMORIAL HOSPITAL (14-0200) 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.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	244,540	17,438	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
200.00 Total	0	244,540	17,438	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/21/2017 1:01 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 60126		4.00 County: DUPAGE				
1.00 Street: 155 E BRUSH HILL ROAD		2.00 State: IL		3.00 Zip Code: 60126		4.00 County: DUPAGE				
2.00 City: ELMHURST		3.00 Zip Code: 60126		4.00 County: DUPAGE			1.00			
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		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ELMHURST MEMORIAL HOSPITAL	140200	16974	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
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.					N	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)					N	N		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.						2	N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,410	0	54	0	4,961	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/21/2017 1:01 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	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
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)	Y				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
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)							61.06		
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count 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	0.000000	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.			N		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)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00	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.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	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)					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.					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		Speech		Respiratory	
		1.00		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.					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.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		5,621,792	
						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: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/21/2017 1:01 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	14H131	140.00			
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: EDWARD ELMHURST HEALTH	Contractor's Name: NGS		Contractor's Number: 00131		141.00	
142.00	Street: 801 SOUTH WASHINGTON STREET	PO Box:				142.00	
143.00	City: NAPERVILLE	State: IL	Zip Code: 60540	143.00			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00			
		1.00	2.00				
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00			
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00			
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00			
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
				1.00			
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			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	N		167.00			
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0		168.00			
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01			
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00		169.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/21/2017 1:01 pm
			Beginning	Ending
			1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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)			0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/21/2017 1:01 pm		
				Y/N	Date			
				1.00	2.00			
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.								
COMPLETED BY ALL HOSPITALS								
Provider Organization and Operation								
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00	
				Y/N	Date	V/I		
				1.00	2.00	3.00		
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00	
				Y/N	Type	Date		
				1.00	2.00	3.00		
Financial Data and Reports								
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	10/02/2017	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.			Y			7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00	
						Y/N		
						1.00		
Bad Debts								
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00	
Bed Complement								
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00	
				Part A		Part B		
				Y/N	Date	Y/N	Date	
				1.00	2.00	3.00	4.00	
PS&R Data								
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	11/13/2017	Y	11/13/2017	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)			N		N	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: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/21/2017 1:01 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		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023		TONY@LEONE-CONSULTING.COM	43.00

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2017 1:01 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	247	90,155	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)		247	90,155	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	35	12,775	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		282	102,930	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						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)		282				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: 14-0200

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2017 1:01 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	27,602	1,671	57,446			1.00
2.00 HMO and other (see instructions)	6,540	5,971				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	27,602	1,671	57,446			7.00
8.00 INTENSIVE CARE UNIT	2,100	210	9,924			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		594	5,717			13.00
14.00 Total (see instructions)	29,702	2,475	73,087	0.00	2,241.08	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						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	2,241.08	27.00
28.00 Observation Bed Days		0	5,554			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: 14-0200

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

Worksheet S-3
Part I
Date/Time Prepared:
11/21/2017 1:01 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	6,230	441	17,387	1.00
2.00 HMO and other (see instructions)			1,302	1,352		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	6,230	441	17,387	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						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: 14-0200

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

Worksheet S-3
Part II
Date/Time Prepared:
11/21/2017 1:01 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	137,533,076	0	137,533,076	4,540,586.00	30.29
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		177,455	0	177,455	1,420.00	124.97
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		875,691	0	875,691	7,432.00	117.83
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		595,918	0	595,918	10,821.00	55.07
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,026,106	543,440	2,569,546	89,130.00	28.83
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		257,898	0	257,898	3,533.00	73.00
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		3,014,337	0	3,014,337	24,115.00	125.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		24,647,229	0	24,647,229	662,176.00	37.22
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		29,241,704	0	29,241,704		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		492,907	0	492,907		
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		18,274	0	18,274		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		65,611	0	65,611		
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		5,107,290	0	5,107,290		
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	1,714,747	0	1,714,747	46,221.00	37.10
27.00	Administrative & General	5.00	11,155,346	-406,284	10,749,062	375,868.00	28.60

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0200

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

Worksheet S-3
Part II
Date/Time Prepared:
11/21/2017 1:01 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	
28.00	Administrative & General under contract (see inst.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,685,037	-59,485	2,625,552	70,114.00	37.45
31.00	Laundry & Linen Service	8.00	631,506	-77,671	553,835	40,108.00	13.81
32.00	Housekeeping	9.00	3,669,405	0	3,669,405	244,379.00	15.02
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,617,029	-1,452,893	1,164,136	68,161.00	17.08
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,452,893	1,452,893	77,171.00	18.83
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	2,893,103	0	2,893,103	42,565.00	67.97
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	3,369,553	0	3,369,553	79,555.00	42.36
41.00	Medical Records & Medical Records Library	16.00	1,151,122	0	1,151,122	59,644.00	19.30
42.00	Social Service	17.00	0	0	0	0.00	0.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0200

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

Worksheet S-3
Part III
Date/Time Prepared:
11/21/2017 1:01 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es 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)	136,061,467	0	136,061,467	4,522,333.00	30.09	1.00
2.00	Excluded area salaries (see instructions)	2,026,106	543,440	2,569,546	89,130.00	28.83	2.00
3.00	Subtotal salaries (line 1 minus line 2)	134,035,361	-543,440	133,491,921	4,433,203.00	30.11	3.00
4.00	Subtotal other wages & related costs (see inst.)	27,919,464	0	27,919,464	689,824.00	40.47	4.00
5.00	Subtotal wage-related costs (see inst.)	34,367,268	0	34,367,268	0.00	25.74	5.00
6.00	Total (sum of lines 3 thru 5)	196,322,093	-543,440	195,778,653	5,123,027.00	38.22	6.00
7.00	Total overhead cost (see instructions)	29,886,848	-543,440	29,343,408	1,103,786.00	26.58	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/21/2017 1:01 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	3,684,463	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,333,333	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	11,828,711	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	639,642	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	155,975	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)	936,700	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	302,800	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	10,202,073	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	125,442	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	609,355	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	29,818,494	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0200

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

Worksheet S-3
Part V
Date/Time Prepared:
11/21/2017 1:01 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	257,898	29,818,496	1.00
2.00	Hospital	257,898	29,818,496	2.00
3.00	Subprovider - IPF			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	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-5

Date/Time Prepared:
11/21/2017 1:01 pm

		Outpatient		Training		Home						
		Regular 1.00	High Flux 2.00	Hemodialysis 3.00	CAPD / CCPD 4.00	Hemodialysis 5.00	CAPD / CCPD 6.00					
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00				
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00				
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00				
4.00	CAPD exchanges per day				0.00			4.00				
5.00	Number of days in year dialysis furnished	0	0					5.00				
6.00	Number of stations	0	0	0	0			6.00				
7.00	Treatment capacity per day per station	0	0					7.00				
8.00	Utilization (see instructions)	0.00	0.00					8.00				
9.00	Average times dialyzers re-used	0.00	0.00					9.00				
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00				
								Y/N				
								1.00				
ESRD PPS												
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)							N	10.01			
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)							Y	10.02			
								Prior to 1/1 1.00	After 12/31 2.00			
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)							0	4	10.03		
TRANSPLANT INFORMATION												
11.00	Number of patients on transplant list							0	11.00			
12.00	Number of patients transplanted during the cost reporting period							0	12.00			
EPOETIN												
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.								13.00			
14.00	Epoetin amount from Worksheet A for Home Dialysis program								14.00			
15.00	Number of EPO units furnished relating to the renal dialysis department								15.00			
16.00	Number of EPO units furnished relating to the home dialysis department								16.00			
ARANESP												
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.								17.00			
18.00	ARANESP amount from Worksheet A for Home Dialysis program								18.00			
19.00	Number of ARANESP units furnished relating to the renal dialysis department								19.00			
20.00	Number of ARANESP units furnished relating to the home dialysis department								20.00			
								MCP 1.00	INITIAL METHOD 2.00			
PHYSICIAN PAYMENT METHOD												
21.00	Enter "X" if method(s) is applicable								21.00			
		ESA Description 1.00	Net Cost of ESAs for Renal Patients 2.00	Net Cost of ESAs for Home Patients 3.00	Number of ESA Units - Renal Dialysis Dept. 4.00	Number of ESA Units - Home Dialysis Dept. 5.00						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)							0	0	0	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S-5 Date/Time Prepared: 11/21/2017 1:01 pm
		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-7

Date/Time Prepared:
11/21/2017 1:01 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-7

Date/Time Prepared:
11/21/2017 1:01 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

201.00 SNF SERVICES
 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/21/2017 1:01 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)			0.180659	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			32,676,439	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?			Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			241,008,032	6.00
7.00	Medicaid cost (line 1 times line 6)			43,540,270	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)			10,863,831	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)			10,863,831	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)	36,691,724	1,562,471	38,254,195	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	6,628,690	1,562,471	8,191,161	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	6,628,690	1,562,471	8,191,161	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)			16,966,097	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			691,719	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,064,182	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			15,901,915	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			3,245,287	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			11,436,448	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			22,300,279	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0200

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

Worksheet A
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		15,810,592	15,810,592	-437,326	15,373,266	1.00
2.00	00200		10,215,826	10,215,826	0	10,215,826	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	1,714,747	22,286,050	24,000,797	-3,139	23,997,658	4.00
5.00	00500	11,155,346	98,293,960	109,449,306	-2,350,749	107,098,557	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	2,685,037	12,854,482	15,539,519	-72,143	15,467,376	7.00
8.00	00800	631,506	476,898	1,108,404	-88,491	1,019,913	8.00
9.00	00900	3,669,405	1,094,056	4,763,461	-74,796	4,688,665	9.00
10.00	01000	2,617,029	1,609,535	4,226,564	-2,309,019	1,917,545	10.00
11.00	01100	0	0	0	2,291,785	2,291,785	11.00
13.00	01300	2,893,103	48,373	2,941,476	0	2,941,476	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	3,369,553	30,565,855	33,935,408	-10,584,746	23,350,662	15.00
16.00	01600	1,151,122	5,565	1,156,687	0	1,156,687	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	0	0	0	431,600	431,600	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	25,981,983	3,218,362	29,200,345	-7,225,355	21,974,990	30.00
31.00	03100	6,063,071	887,750	6,950,821	-799,153	6,151,668	31.00
43.00	04300	1,058,219	606	1,058,825	620,128	1,678,953	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	12,538,115	49,461,422	61,999,537	-43,059,078	18,940,459	50.00
52.00	05200	0	0	0	4,403,666	4,403,666	52.00
53.00	05300	190,754	735,377	926,131	-494,710	431,421	53.00
54.00	05400	4,396,786	2,415,624	6,812,410	-2,825,574	3,986,836	54.00
54.01	03630	1,338,417	157,538	1,495,955	-13,659	1,482,296	54.01
55.00	05500	2,568,386	276,943	2,845,329	40,174	2,885,503	55.00
55.01	05501	517,171	2,266,461	2,783,632	66,648	2,850,280	55.01
56.00	05600	589,576	1,298,448	1,888,024	44,340	1,932,364	56.00
57.00	05700	970,531	686,716	1,657,247	-329,792	1,327,455	57.00
58.00	05800	746,026	227,593	973,619	-10,236	963,383	58.00
59.00	05900	1,348,734	6,617,405	7,966,139	-6,578,501	1,387,638	59.00
60.00	06000	7,075,703	11,099,834	18,175,537	-6,140,558	12,034,979	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,868,620	574,725	2,443,345	-286,797	2,156,548	65.00
65.01	03610	483,780	41,588	525,368	-3,286	522,082	65.01
66.00	06600	3,430,476	59,031	3,489,507	-60,539	3,428,968	66.00
67.00	06700	594,331	4,524	598,855	39,589	638,444	67.00
68.00	06800	243,887	1,343	245,230	-92	245,138	68.00
69.00	06900	901,729	2,073,568	2,975,297	-201,606	2,773,691	69.00
70.00	07000	297,596	6,211	303,807	-6,202	297,605	70.00
71.00	07100	0	0	0	27,172,175	27,172,175	71.00
72.00	07200	0	0	0	39,172,094	39,172,094	72.00
73.00	07300	0	0	0	10,405,973	10,405,973	73.00
74.00	07400	0	857,895	857,895	0	857,895	74.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	442,592	9,560	452,152	-1,091	451,061	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	22,921,887	11,509,314	34,431,201	-695,095	33,736,106	90.00
90.01	09001	2,832,226	1,427,536	4,259,762	-251,750	4,008,012	90.01
90.02	09003	0	0	0	552,453	552,453	90.02
91.00	09100	6,219,526	1,880,598	8,100,124	-783,790	7,316,334	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		-122,080	-122,080	122,080	0	113.00
118.00		135,506,970	290,935,084	426,442,054	-324,568	426,117,486	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	364,192	791,852	1,156,044	0	1,156,044	190.00
190.01	19001	382,777	10,000	392,777	0	392,777	190.01
192.00	19200	0	737,399	737,399	324,568	1,061,967	192.00
192.01	19201	966,529	1,923	968,452	0	968,452	192.01
194.00	07950	312,608	1,626,717	1,939,325	0	1,939,325	194.00
200.00		137,533,076	294,102,975	431,636,051	0	431,636,051	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0200

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

Worksheet A
Date/Time Prepared:
11/21/2017 1:01 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	13,617,091	28,990,357	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,373,342	13,589,168	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,743,506	28,741,164	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-17,730,008	89,368,549	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-558,173	14,909,203	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-293,363	726,550	8.00
9.00	00900	HOUSEKEEPING	-48,310	4,640,355	9.00
10.00	01000	DIETARY	-53,849	1,863,696	10.00
11.00	01100	CAFETERIA	-1,689,017	602,768	11.00
13.00	01300	NURSING ADMINISTRATION	-104,351	2,837,125	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	194,720	23,545,382	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,712,901	3,869,588	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	0	431,600	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,013,399	20,961,591	30.00
31.00	03100	INTENSIVE CARE UNIT	-3,682	6,147,986	31.00
43.00	04300	NURSERY	-284,495	1,394,458	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	18,940,459	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,403,666	52.00
53.00	05300	ANESTHESIOLOGY	0	431,421	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-58,666	3,928,170	54.00
54.01	03630	ULTRASOUND	0	1,482,296	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,885,503	55.00
55.01	05501	CYBERKNIFE	0	2,850,280	55.01
56.00	05600	RADIOISOTOPE	0	1,932,364	56.00
57.00	05700	CT SCAN	0	1,327,455	57.00
58.00	05800	MRI	0	963,383	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,387,638	59.00
60.00	06000	LABORATORY	-3,353,005	8,681,974	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-42,504	2,114,044	65.00
65.01	03610	SLEEP LAB	0	522,082	65.01
66.00	06600	PHYSICAL THERAPY	-13,424	3,415,544	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	638,444	67.00
68.00	06800	SPEECH PATHOLOGY	0	245,138	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,836,341	937,350	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	297,605	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	27,172,175	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,172,094	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,405,973	73.00
74.00	07400	RENAL DIALYSIS	0	857,895	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	451,061	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-3,876,252	29,859,854	90.00
90.01	09001	OUTPATIENT CLINICS	-1,086,419	2,921,593	90.01
90.02	09003	OUTPATIENT SERVICES	0	552,453	90.02
91.00	09100	EMERGENCY	-249,555	7,066,779	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)	-7,653,253	418,464,233	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,156,044	190.00
190.01	19001	FOUNDATION	0	392,777	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,521	1,088,488	192.00
192.01	19201	SCHOOL NURSES	0	968,452	192.01
194.00	07950	OUTPATIENT PHARMACY	0	1,939,325	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-7,626,732	424,009,319	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	1,452,893	838,892	1.00
	TOTALS		1,452,893	838,892	
C - DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,405,973	1.00
	TOTALS		0	10,405,973	
D - RADIOLOGY SUPPORT					
1.00	ULTRASOUND	54.01	122,972	1,526	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	235,981	2,684	2.00
3.00	CYBERKNIFE	55.01	47,517	21,961	3.00
4.00	RADIOISOTOPE	56.00	54,170	12,582	4.00
5.00	CT SCAN	57.00	89,171	6,654	5.00
6.00	MRI	58.00	68,544	2,205	6.00
	TOTALS		618,355	47,612	
E - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	27,172,175	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
	TOTALS		0	27,172,175	
G - NURSERY					
1.00	NURSERY	43.00	335,588	45	1.00
	TOTALS		335,588	45	
H - PARAMEDICAL ED PASTORAL CARE					
1.00	PARAMEDICAL PRGM-PASTORAL CARE	23.00	406,284	25,316	1.00
	TOTALS		406,284	25,316	
I - REHAB ADMIN					
1.00	OCCUPATIONAL THERAPY	67.00	41,953	1,372	1.00
2.00	SPEECH PATHOLOGY	68.00	17,216	407	2.00
	TOTALS		59,169	1,779	
J - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	39,172,094	1.00
2.00	CARDIAC REHABILITATION	76.97	0	6,115	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
10.00		0.00	0	0	10.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	39,178,209	

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
K - LOMBARD POB COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	109,539	84,552	1.00
2.00		0.00	0	0	2.00
	TOTALS		109,539	84,552	
L - POB BUILDING COSTS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	27,617	102,860	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	147,865	2.00
3.00	OPERATION OF PLANT	7.00	0	64,521	3.00
	TOTALS		27,617	315,246	
M - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	789,094	1.00
2.00	NURSERY	43.00	0	284,495	2.00
3.00	OPERATING ROOM	50.00	0	239,209	3.00
4.00	EMERGENCY	91.00	0	418,782	4.00
5.00	RESPIRATORY THERAPY	65.00	0	42,504	5.00
6.00	CLINIC	90.00	0	206,873	6.00
	TOTALS		0	1,980,957	
N - INTEREST EXP TO LINE 1					
1.00	INTEREST EXPENSE	113.00	0	122,080	1.00
	TOTALS		0	122,080	
O - OUTPATIENT SERVICE RECLASS					
1.00	OUTPATIENT SERVICES	90.02	500,583	51,870	1.00
	TOTALS		500,583	51,870	
P - DELIVERY & LABOR					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	3,478,403	925,263	1.00
	TOTALS		3,478,403	925,263	
500.00	Grand Total: Increases		6,988,431	81,149,969	500.00

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6
Date/Time Prepared:
11/21/2017 1:01 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	1,452,893	838,892	0	1.00
	TOTALS		1,452,893	838,892		
C - DRUGS SOLD						
1.00	PHARMACY	15.00	0	10,405,973	0	1.00
	TOTALS		0	10,405,973		
D - RADIOLOGY SUPPORT						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	618,355	47,612	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	TOTALS		618,355	47,612		
E - CHARGEABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,139	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	86,057	0	2.00
3.00	OPERATION OF PLANT	7.00	0	301	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	3,146	0	4.00
5.00	HOUSEKEEPING	9.00	0	74,796	0	5.00
6.00	DIETARY	10.00	0	17,234	0	6.00
7.00	PHARMACY	15.00	0	178,773	0	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	2,585,201	0	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	795,928	0	9.00
10.00	OPERATING ROOM	50.00	0	9,348,416	0	10.00
11.00	ANESTHESIOLOGY	53.00	0	494,398	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,828,717	0	12.00
13.00	ULTRASOUND	54.01	0	137,778	0	13.00
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	198,491	0	14.00
15.00	CYBERKNIFE	55.01	0	2,830	0	15.00
16.00	RADIOISOTOPE	56.00	0	22,412	0	16.00
17.00	CT SCAN	57.00	0	422,209	0	17.00
18.00	MRI	58.00	0	80,985	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	1,888,043	0	19.00
20.00	LABORATORY	60.00	0	6,140,558	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	329,301	0	21.00
22.00	SLEEP LAB	65.01	0	3,286	0	22.00
23.00	PHYSICAL THERAPY	66.00	0	17,194	0	23.00
24.00	OCCUPATIONAL THERAPY	67.00	0	3,736	0	24.00
25.00	SPEECH PATHOLOGY	68.00	0	92	0	25.00
26.00	ELECTROCARDIOLOGY	69.00	0	201,606	0	26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,202	0	27.00
29.00	CARDIAC REHABILITATION	76.97	0	7,206	0	29.00
30.00	CLINIC	90.00	0	882,372	0	30.00
31.00	OUTPATIENT CLINICS	90.01	0	242,038	0	31.00
32.00	EMERGENCY	91.00	0	1,169,730	0	32.00
	TOTALS		0	27,172,175		
G - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	335,588	45	0	1.00
	TOTALS		335,588	45		
H - PARAMEDICAL ED PASTORAL CARE						
1.00	ADMINISTRATIVE & GENERAL	5.00	406,284	25,316	0	1.00
	TOTALS		406,284	25,316		
I - REHAB ADMIN						
1.00	PHYSICAL THERAPY	66.00	41,953	1,372	0	1.00
2.00	SPEECH PATHOLOGY	68.00	17,216	407	0	2.00
	TOTALS		59,169	1,779		
J - IMPLANTS						
1.00	ADULTS & PEDIATRICS	30.00	0	137,496	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	3,225	0	2.00
3.00	OPERATING ROOM	50.00	0	33,949,871	0	3.00
4.00	ANESTHESIOLOGY	53.00	0	312	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	330,890	0	5.00
6.00	ULTRASOUND	54.01	0	379	0	6.00
7.00	CT SCAN	57.00	0	3,408	0	7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	4,690,458	0	8.00
10.00	PHYSICAL THERAPY	66.00	0	20	0	10.00
12.00	CLINIC	90.00	0	19,596	0	12.00
13.00	OUTPATIENT CLINICS	90.01	0	9,712	0	13.00
14.00	EMERGENCY	91.00	0	32,842	0	14.00
	TOTALS		0	39,178,209		

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
K - LOMBARD POB COSTS							
1.00	OPERATION OF PLANT	7.00	31,868	76,878	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	77,671	7,674	0		2.00
	TOTALS		109,539	84,552			
L - POB BUILDING COSTS							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	315,246	9		1.00
2.00	OPERATION OF PLANT	7.00	27,617	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		27,617	315,246			
M - PHYSICIAN FEES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,980,957	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	1,980,957			
N - INTEREST EXP TO LINE 1							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	122,080	11		1.00
	TOTALS		0	122,080			
O - OUTPATIENT SERVICE RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	500,583	51,870	0		1.00
	TOTALS		500,583	51,870			
P - DELIVERY & LABOR							
1.00	ADULTS & PEDIATRICS	30.00	3,478,403	925,263	0		1.00
	TOTALS		3,478,403	925,263			
500.00	Grand Total: Decreases		6,988,431	81,149,969			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

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

Worksheet A-7
Part I
Date/Time Prepared:
11/21/2017 1:01 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	31,291,794	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	445,831,527	13,388,354	0	13,388,354	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	188,489,912	33,333,897	0	33,333,897	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	665,613,233	46,722,251	0	46,722,251	0	8.00
9.00	Reconciling Items	0	0	71	71	0	9.00
10.00	Total (line 8 minus line 9)	665,613,233	46,722,251	-71	46,722,180	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	31,291,794	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	459,219,881	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	221,823,809	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	712,335,484	0				8.00
9.00	Reconciling Items	71	0				9.00
10.00	Total (line 8 minus line 9)	712,335,413	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

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

Worksheet A-7
Part II
Date/Time Prepared:
11/21/2017 1:01 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	15,810,592	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,215,826	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	26,026,418	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	15,810,592				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,215,826				2.00
3.00	Total (sum of lines 1-2)	0	26,026,418				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

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

Worksheet A-7
Part III
Date/Time Prepared:
11/21/2017 1:01 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	490,511,217	0	490,511,217	0.688596	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	221,824,196	0	221,824,196	0.311404	0	2.00
3.00	Total (sum of lines 1-2)	712,335,413	0	712,335,413	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	16,775,864	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	13,589,168	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	30,365,032	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	12,214,493	0	0	0	28,990,357	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	13,589,168	2.00
3.00	Total (sum of lines 1-2)	12,214,493	0	0	0	42,579,525	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0200

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

Worksheet A-8

Date/Time Prepared:
11/21/2017 1:01 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	-370,854	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-38,878	ADMINISTRATIVE & GENERAL		5.00	0 7.00
8.00 Television and radio service (chapter 21)		0			0.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-7,727,586				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	10,775,669				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-1,689,017	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines	B	-53,849	DIETARY		10.00	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		0			0.00	0 33.00
33.01 OTHER OPERATING REVENUE	B	1	ADMINISTRATIVE & GENERAL		5.00	0 33.01

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		4.00
33.02		0			0.00	0	33.02
33.03		0			0.00	0	33.03
33.04	PATIENT PHONE DEPRECIATION	-3,990	CAP REL COSTS-MVBLE EQUIP		2.00	9	33.04
33.05		0			0.00	0	33.05
33.06		0			0.00	0	33.06
33.07		0			0.00	0	33.07
33.08	LOBBYING PORTION OF DUES	-80,103	ADMINISTRATIVE & GENERAL		5.00	0	33.08
33.09		0			0.00	0	33.09
33.10		0			0.00	0	33.10
34.00	DONATIONS	-221,508	ADMINISTRATIVE & GENERAL		5.00	0	34.00
35.00	PHYSICIAN PROFESSIONAL COMPONENT	26,521	PHYSICIANS' PRIVATE OFFICES		192.00	0	35.00
36.00		0			0.00	0	36.00
36.01	OTHER REVENUE	-50,365	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	36.01
36.02	OTHER REVENUE	-2,785,224	ADMINISTRATIVE & GENERAL		5.00	0	36.02
36.03	OTHER REVENUE	-558,173	OPERATION OF PLANT		7.00	0	36.03
36.04	OTHER REVENUE	-293,363	LAUNDRY & LINEN SERVICE		8.00	0	36.04
36.05	OTHER REVENUE	-48,310	HOUSEKEEPING		9.00	0	36.05
36.06		0			0.00	0	36.06
36.07		0			0.00	0	36.07
36.08	OTHER REVENUE	-104,351	NURSING ADMINISTRATION		13.00	0	36.08
36.09	OTHER REVENUE	-3,000	PHARMACY		15.00	0	36.09
36.10	OTHER REVENUE	-291,087	ADULTS & PEDIATRICS		30.00	0	36.10
36.11	OTHER REVENUE	-3,682	INTENSIVE CARE UNIT		31.00	0	36.11
36.12	OTHER REVENUE	-58,666	RADIOLOGY-DIAGNOSTIC		54.00	0	36.12
36.13		0			0.00	0	36.13
36.14	OTHER REVENUE	-2,714,613	LABORATORY		60.00	0	36.14
36.15	OTHER REVENUE	-13,424	PHYSICAL THERAPY		66.00	0	36.15
36.16	OTHER REVENUE	-5,971	ELECTROCARDIOLOGY		69.00	0	36.16
36.17	OTHER REVENUE	-1,017,008	CLINIC		90.00	0	36.17
36.18	OTHER REVENUE	-146,390	OUTPATIENT CLINICS		90.01	0	36.18
36.19	OTHER REVENUE	-149,511	EMERGENCY		91.00	0	36.19
36.20	OTHER ADJUSTMENTS (SPECIFY) (3)	0			0.00	0	36.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	-7,626,732					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: 14-0200
 Period: From 07/01/2016 To 06/30/2017
 Worksheet A-8-1
 Date/Time Prepared: 11/21/2017 1:01 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	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION EXPENSE	1,280,518	0 1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION EXPENSE	3,377,332	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	4,793,871	0 3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	A & G	42,135,878	59,533,206 3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	7,669,693	4,566,465 3.02
3.03	15.00	PHARMACY	RX	197,720	0 3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	2,712,901	0 3.04
3.05	1.00	CAP REL COSTS-BLDG & FIXT	ELMHURST MEMORIAL HEALTHCARE	13,916,012	0 3.05
4.00	1.00	CAP REL COSTS-BLDG & FIXT	ELMHURST HEALTHCARE INT. IN	-5,554,340	0 4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	ELMHURST HEALTHCARE LOSS ON	4,345,755	0 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			74,875,340	64,099,671 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B	EDWARD ELMHURST HEALTH	100.00	0.00	6.00
7.00	B	ELMHURST MEMORI	100.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:			0.00	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: 14-0200

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

Worksheet A-8-2

Date/Time Prepared:
11/21/2017 1:01 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	310,196	310,196	0	0	0	1.00
2.00	60.00	LABORATORY	638,392	638,392	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	1,865,349	1,822,365	42,984	211,500	344	3.00
4.00	90.00	CLINIC	3,780,896	2,647,918	1,132,978	211,500	9,064	4.00
5.00	90.01	OUTPATIENT CLINICS	940,029	940,029	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	722,312	722,312	0	0	0	6.00
7.00	91.00	EMERGENCY	100,044	100,044	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	42,504	42,504	0	0	0	8.00
9.00	43.00	NURSERY	25,863	25,863	0	0	0	9.00
10.00	43.00	NURSERY	258,632	258,632	0	0	0	10.00
200.00			8,684,217	7,508,255	1,175,962		9,408	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	34,979	1,749	0	0	0	3.00
4.00	90.00	CLINIC	921,652	46,083	0	0	0	4.00
5.00	90.01	OUTPATIENT CLINICS	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	43.00	NURSERY	0	0	0	0	0	9.00
10.00	43.00	NURSERY	0	0	0	0	0	10.00
200.00			956,631	47,832	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	310,196	1.00
2.00	60.00	LABORATORY	0	0	0	638,392	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	34,979	8,005	1,830,370	3.00
4.00	90.00	CLINIC	0	921,652	211,326	2,859,244	4.00
5.00	90.01	OUTPATIENT CLINICS	0	0	0	940,029	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	722,312	6.00
7.00	91.00	EMERGENCY	0	0	0	100,044	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	42,504	8.00
9.00	43.00	NURSERY	0	0	0	25,863	9.00
10.00	43.00	NURSERY	0	0	0	258,632	10.00
200.00			0	956,631	219,331	7,727,586	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	28,990,357	28,990,357			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	13,589,168		13,589,168		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	28,741,164	259,933	25,628	29,026,725	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	89,368,549	3,775,442	4,596,671	2,297,257	100,037,919
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	14,909,203	1,501,853	1,156,304	561,125	18,128,485
8.00 00800	LAUNDRY & LINEN SERVICE	726,550	71,500	27,526	118,364	943,940
9.00 00900	HOUSEKEEPING	4,640,355	66,067	34,331	784,214	5,524,967
10.00 01000	DIETARY	1,863,696	563,151	200,748	248,796	2,876,391
11.00 01100	CAFETERIA	602,768	789,831	0	310,508	1,703,107
13.00 01300	NURSING ADMINISTRATION	2,837,125	38,642	5,084	618,305	3,499,156
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	23,545,382	110,054	118,419	720,131	24,493,986
16.00 01600	MEDICAL RECORDS & LIBRARY	3,869,588	80,043	37,135	246,014	4,232,780
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00 02300	PARAMED ED PRGM-PASTORAL CARE	431,600	113,909	108	86,830	632,447
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	20,961,591	9,732,559	1,094,055	4,630,694	36,418,899
31.00 03100	INTENSIVE CARE UNIT	6,147,986	1,373,223	107,537	1,295,781	8,924,527
43.00 04300	NURSERY	1,394,458	0	0	297,880	1,692,338
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	18,940,459	2,767,212	2,044,845	2,679,608	26,432,124
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,403,666	0	0	743,394	5,147,060
53.00 05300	ANESTHESIOLOGY	431,421	17,349	72,700	40,767	562,237
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,928,170	815,110	605,013	807,515	6,155,808
54.01 03630	ULTRASOUND	1,482,296	79,211	138,174	312,324	2,012,005
55.00 05500	RADIOLOGY-THERAPEUTIC	2,885,503	1,318,721	823,763	599,341	5,627,328
55.01 05501	CYBERKNIFE	2,850,280	0	0	120,683	2,970,963
56.00 05600	RADIOISOTOPE	1,932,364	181,729	36,876	137,579	2,288,548
57.00 05700	CT SCAN	1,327,455	117,546	122,968	226,476	1,794,445
58.00 05800	MRI	963,383	121,620	223,101	174,087	1,482,191
59.00 05900	CARDIAC CATHETERIZATION	1,387,638	547,466	645,305	288,247	2,868,656
60.00 06000	LABORATORY	8,681,974	1,287,790	519,720	1,512,198	12,001,682
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	2,114,044	276,712	55,922	399,356	2,846,034
65.01 03610	SLEEP LAB	522,082	0	22,957	103,392	648,431
66.00 06600	PHYSICAL THERAPY	3,415,544	70,624	15,085	724,185	4,225,438
67.00 06700	OCCUPATIONAL THERAPY	638,444	70,536	3,693	135,985	848,658
68.00 06800	SPEECH PATHOLOGY	245,138	0	0	52,123	297,261
69.00 06900	ELECTROCARDIOLOGY	937,350	491,695	117,480	192,715	1,739,240
70.00 07000	ELECTROENCEPHALOGRAPHY	297,605	0	0	63,601	361,206
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,172,175	0	0	0	27,172,175
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	39,172,094	0	0	0	39,172,094
73.00 07300	DRUGS CHARGED TO PATIENTS	10,405,973	0	0	0	10,405,973
74.00 07400	RENAL DIALYSIS	857,895	38,554	661	0	897,110
76.00 03020	CARDIAC REHABILITATION	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	451,061	0	28,051	94,589	573,701
76.98 07698	HYPERBARIIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	29,859,854	0	524,866	4,898,838	35,283,558
90.01 09001	OUTPATIENT CLINICS	2,921,593	0	44,042	605,295	3,570,930
90.02 09003	OUTPATIENT SERVICES	552,453	224,840	25,277	106,983	909,553
91.00 09100	EMERGENCY	7,066,779	1,446,694	103,993	1,329,218	9,946,684
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	418,464,233	28,349,616	13,578,038	28,564,398	417,350,035
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,156,044	289,505	11,130	77,834	1,534,513
190.01 19001	FOUNDATION	392,777	0	0	81,806	474,583
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,088,488	351,236	0	29,313	1,469,037
192.01 19201	SCHOOL NURSES	968,452	0	0	206,564	1,175,016
194.00 07950	OUTPATIENT PHARMACY	1,939,325	0	0	66,810	2,006,135
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	424,009,319	28,990,357	13,589,168	29,026,725	424,009,319

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2017 1:01 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	100,037,919					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	5,597,822	0	23,726,307			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	291,475	0	72,333	1,307,748		8.00
9.00	00900	HOUSEKEEPING	1,706,032	0	66,837	9,887	7,307,723	9.00
10.00	01000	DIETARY	888,189	0	569,710	0	176,507	10.00
11.00	01100	CAFETERIA	525,896	0	799,031	0	247,554	11.00
13.00	01300	NURSING ADMINISTRATION	1,080,490	0	39,092	0	12,111	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	7,563,400	0	111,336	0	34,494	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,307,023	0	80,976	0	25,088	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	195,291	0	115,236	0	35,702	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,245,646	0	9,845,920	258,176	3,050,444	30.00
31.00	03100	INTENSIVE CARE UNIT	2,755,769	0	1,389,218	68,341	430,405	31.00
43.00	04300	NURSERY	522,570	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,161,870	0	2,799,444	123,266	867,318	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,589,340	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	173,611	0	17,551	0	5,438	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,900,827	0	824,604	48,861	255,477	54.00
54.01	03630	ULTRASOUND	621,279	0	80,134	728	24,827	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,737,640	0	1,334,081	1,888	413,323	55.00
55.01	05501	CYBERKNIFE	917,392	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	706,672	0	183,846	9,546	56,959	56.00
57.00	05700	CT SCAN	554,099	0	118,915	6,386	36,842	57.00
58.00	05800	MRI	457,680	0	123,037	16,729	38,119	58.00
59.00	05900	CARDIAC CATHETERIZATION	885,801	0	553,843	17,745	171,591	59.00
60.00	06000	LABORATORY	3,705,951	0	1,302,790	232	403,628	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	878,815	0	279,936	0	86,729	65.00
65.01	03610	SLEEP LAB	200,226	0	0	3,200	0	65.01
66.00	06600	PHYSICAL THERAPY	1,304,756	0	71,446	2,749	22,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,054	0	71,358	0	22,108	67.00
68.00	06800	SPEECH PATHOLOGY	91,790	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	537,053	0	497,422	0	154,110	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,535	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,390,387	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,095,884	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,213,219	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	277,015	0	39,003	1,515	12,084	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	177,151	0	0	379	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,895,069	0	0	11,728	0	90.00
90.01	09001	OUTPATIENT CLINICS	1,102,653	0	0	14,685	0	90.01
90.02	09003	OUTPATIENT SERVICES	280,857	0	227,459	5,965	70,471	90.02
91.00	09100	EMERGENCY	3,071,397	0	1,463,545	119,794	453,433	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)	97,981,626	0	23,078,103	721,800	7,106,897	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	473,836	0	292,877	7,098	90,739	190.00
190.01	19001	FOUNDATION	146,545	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	453,618	0	355,327	578,850	110,087	192.00
192.01	19201	SCHOOL NURSES	362,828	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	619,466	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	100,037,919	0	23,726,307	1,307,748	7,307,723	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/21/2017 1:01 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	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	4,510,797					10.00
11.00	01100	CAFETERIA	0	3,275,588				11.00
13.00	01300	NURSING ADMINISTRATION	0	37,480	4,668,329			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	70,050	0	0	32,273,266	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,464	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	16,762	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,048,241	692,311	2,083,257	0	5,901	30.00
31.00	03100	INTENSIVE CARE UNIT	462,556	144,804	435,734	0	308	31.00
43.00	04300	NURSERY	0	22,393	67,383	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	347,733	1,046,375	0	17,499	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	7,886	23,730	0	188,781	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	154,464	0	0	223	54.00
54.01	03630	ULTRASOUND	0	0	0	0	1,926	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	71,217	214,302	0	3	55.00
55.01	05501	CYBERKNIFE	0	0	0	0	0	55.01
56.00	05600	RADIO SOTOPE	0	12,868	0	0	1,045,337	56.00
57.00	05700	CT SCAN	0	22,086	0	0	57,220	57.00
58.00	05800	MRI	0	16,383	0	0	377	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	28,107	0	0	0	59.00
60.00	06000	LABORATORY	0	235,194	0	0	863,780	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	66,646	0	0	2,801	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	91,286	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,416	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,966	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	21,891	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,871	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	24,542,253	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,918	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	11,515	34,649	0	6	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	798,631	0	0	4,126,475	90.00
90.01	09001	OUTPATIENT CLINICS	0	64,045	192,721	0	7,610	90.01
90.02	09003	OUTPATIENT SERVICES	0	15,995	48,130	0	0	90.02
91.00	09100	EMERGENCY	0	173,488	522,048	0	86,228	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)	4,510,797	3,206,952	4,668,329	0	30,948,646	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,864	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,023	0	0	0	192.00
192.01	19201	SCHOOL NURSES	0	36,755	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	6,994	0	0	1,324,620	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,510,797	3,275,588	4,668,329	0	32,273,266	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM-PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	5,706,331					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	0	995,438			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	521,413	0	577,794	68,748,002	0	30.00
31.00	03100	INTENSIVE CARE UNIT	108,453	0	157,009	14,877,124	0	31.00
43.00	04300	NURSERY	34,555	0	0	2,339,239	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	536,677	0	0	40,332,306	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	74,669	0	0	6,811,069	0	52.00
53.00	05300	ANESTHESIOLOGY	222,188	0	0	1,201,422	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	183,973	0	0	9,524,237	0	54.00
54.01	03630	ULTRASOUND	79,236	0	0	2,820,135	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	94,672	0	0	9,494,454	0	55.00
55.01	05501	CYBERKNIFE	35,183	0	0	3,923,538	0	55.01
56.00	05600	RADIOISOTOPE	47,746	0	0	4,351,522	0	56.00
57.00	05700	CT SCAN	359,409	0	0	2,949,402	0	57.00
58.00	05800	MRI	131,038	0	0	2,265,554	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	138,699	0	0	4,664,442	0	59.00
60.00	06000	LABORATORY	500,363	0	0	19,013,620	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	79,985	0	0	4,240,946	0	65.00
65.01	03610	SLEEP LAB	17,118	0	0	868,975	0	65.01
66.00	06600	PHYSICAL THERAPY	63,957	0	0	5,781,767	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	13,312	0	0	1,229,906	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,718	0	0	399,735	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78,181	0	0	3,027,897	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,239	0	0	490,851	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	278,825	0	0	35,841,387	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	346,971	0	0	51,614,949	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,022,946	0	0	39,184,391	0	73.00
74.00	07400	RENAL DIALYSIS	7,201	0	0	1,235,846	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	8,470	0	0	805,871	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	211,463	0	0	51,326,924	0	90.00
90.01	09001	OUTPATIENT CLINICS	28,760	0	103,626	5,085,030	0	90.01
90.02	09003	OUTPATIENT SERVICES	12,064	0	0	1,570,494	0	90.02
91.00	09100	EMERGENCY	450,847	0	157,009	16,444,473	0	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)	5,706,331	0	995,438	412,465,508	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	2,416,927	0	190.00
190.01	19001	FOUNDATION	0	0	0	621,128	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,973,942	0	192.00
192.01	19201	SCHOOL NURSES	0	0	0	1,574,599	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	3,957,215	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,706,331	0	995,438	424,009,319	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B
Part I
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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
23.00	02300	PARAMED PRGM-PASTORAL CARE	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
55.01	05501	CYBERKNIFE	55.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	03610	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	CARDIAC REHABILITATION	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT CLINICS	90.01
90.02	09003	OUTPATIENT SERVICES	90.02
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
190.01	19001	FOUNDATION	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SCHOOL NURSES	192.01
194.00	07950	OUTPATIENT PHARMACY	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

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

Worksheet B
Part II
Date/Time Prepared:
11/21/2017 1:01 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	259,933	25,628	285,561	285,561 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	3,775,442	4,596,671	8,372,113	22,605 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	1,501,853	1,156,304	2,658,157	5,522 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	71,500	27,526	99,026	1,165 8.00
9.00 00900	HOUSEKEEPING	0	66,067	34,331	100,398	7,717 9.00
10.00 01000	DIETARY	0	563,151	200,748	763,899	2,448 10.00
11.00 01100	CAFETERIA	0	789,831	0	789,831	3,055 11.00
13.00 01300	NURSING ADMINISTRATION	0	38,642	5,084	43,726	6,084 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
15.00 01500	PHARMACY	0	110,054	118,419	228,473	7,086 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	80,043	37,135	117,178	2,421 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
23.00 02300	PARAMED PRGM-PASTORAL CARE	0	113,909	108	114,017	854 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	9,732,559	1,094,055	10,826,614	45,567 30.00
31.00 03100	INTENSIVE CARE UNIT	0	1,373,223	107,537	1,480,760	12,751 31.00
43.00 04300	NURSERY	0	0	0	0	2,931 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	2,767,212	2,044,845	4,812,057	26,368 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	7,315 52.00
53.00 05300	ANESTHESIOLOGY	0	17,349	72,700	90,049	401 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	815,110	605,013	1,420,123	7,946 54.00
54.01 03630	ULTRASOUND	0	79,211	138,174	217,385	3,073 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	1,318,721	823,763	2,142,484	5,898 55.00
55.01 05501	CYBERKNIFE	0	0	0	0	1,188 55.01
56.00 05600	RADIOISOTOPE	0	181,729	36,876	218,605	1,354 56.00
57.00 05700	CT SCAN	0	117,546	122,968	240,514	2,229 57.00
58.00 05800	MRI	0	121,620	223,101	344,721	1,713 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	547,466	645,305	1,192,771	2,836 59.00
60.00 06000	LABORATORY	0	1,287,790	519,720	1,807,510	14,880 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	0	276,712	55,922	332,634	3,930 65.00
65.01 03610	SLEEP LAB	0	0	22,957	22,957	1,017 65.01
66.00 06600	PHYSICAL THERAPY	0	70,624	15,085	85,709	7,126 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	70,536	3,693	74,229	1,338 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	513 68.00
69.00 06900	ELECTROCARDIOLOGY	0	491,695	117,480	609,175	1,896 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	626 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	38,554	661	39,215	0 74.00
76.00 03020	CARDIAC REHABILITATION	0	0	0	0	0 76.00
76.97 07697	CARDIAC REHABILITATION	0	0	28,051	28,051	931 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	524,866	524,866	48,139 90.00
90.01 09001	OUTPATIENT CLINICS	0	0	44,042	44,042	5,956 90.01
90.02 09003	OUTPATIENT SERVICES	0	224,840	25,277	250,117	1,053 90.02
91.00 09100	EMERGENCY	0	1,446,694	103,993	1,550,687	13,080 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)	0	28,349,616	13,578,038	41,927,654	281,012 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	289,505	11,130	300,635	766 190.00
190.01 19001	FOUNDATION	0	0	0	0	805 190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	351,236	0	351,236	288 192.00
192.01 19201	SCHOOL NURSES	0	0	0	0	2,033 192.01
194.00 07950	OUTPATIENT PHARMACY	0	0	0	0	657 194.00
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)	0	28,990,357	13,589,168	42,579,525	285,561 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/21/2017 1:01 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	8,394,718				5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00	
7.00	00700	OPERATION OF PLANT	469,745	0	3,133,424		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	24,459	0	9,553	134,203	8.00	
9.00	00900	HOUSEKEEPING	143,163	0	8,827	1,015	261,120	9.00
10.00	01000	DIETARY	74,533	0	75,239	0	6,307	10.00
11.00	01100	CAFETERIA	44,131	0	105,524	0	8,846	11.00
13.00	01300	NURSING ADMINISTRATION	90,670	0	5,163	0	433	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	634,688	0	14,704	0	1,233	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	109,680	0	10,694	0	896	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	16,388	0	15,219	0	1,276	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	943,687	0	1,300,301	26,494	108,999	30.00
31.00	03100	INTENSIVE CARE UNIT	231,252	0	183,468	7,013	15,379	31.00
43.00	04300	NURSERY	43,852	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	684,909	0	369,710	12,650	30,991	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	133,371	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,569	0	2,318	0	194	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	159,509	0	108,902	5,014	9,129	54.00
54.01	03630	ULTRASOUND	52,135	0	10,583	75	887	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	145,815	0	176,186	194	14,769	55.00
55.01	05501	CYBERKNIFE	76,984	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	59,301	0	24,280	980	2,035	56.00
57.00	05700	CT SCAN	46,498	0	15,705	655	1,316	57.00
58.00	05800	MRI	38,407	0	16,249	1,717	1,362	58.00
59.00	05900	CARDIAC CATHETERIZATION	74,333	0	73,144	1,821	6,131	59.00
60.00	06000	LABORATORY	310,988	0	172,054	24	14,422	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	73,746	0	36,970	0	3,099	65.00
65.01	03610	SLEEP LAB	16,802	0	0	328	0	65.01
66.00	06600	PHYSICAL THERAPY	109,490	0	9,436	282	791	66.00
67.00	06700	OCCUPATIONAL THERAPY	21,990	0	9,424	0	790	67.00
68.00	06800	SPEECH PATHOLOGY	7,703	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	45,067	0	65,692	0	5,507	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,360	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	704,085	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,014,997	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	269,640	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	23,246	0	5,151	155	432	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	14,866	0	0	39	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	914,268	0	0	1,204	0	90.00
90.01	09001	OUTPATIENT CLINICS	92,530	0	0	1,507	0	90.01
90.02	09003	OUTPATIENT SERVICES	23,568	0	30,039	612	2,518	90.02
91.00	09100	EMERGENCY	257,738	0	193,284	12,293	16,202	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)	8,222,163	0	3,047,819	74,072	253,944	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	39,762	0	38,679	728	3,242	190.00
190.01	19001	FOUNDATION	12,297	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,066	0	46,926	59,403	3,934	192.00
192.01	19201	SCHOOL NURSES	30,447	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	51,983	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,394,718	0	3,133,424	134,203	261,120	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/21/2017 1:01 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	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	922,426					10.00
11.00	01100	CAFETERIA	0	951,387				11.00
13.00	01300	NURSING ADMINISTRATION	0	10,886	156,962			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	20,346	0	0	906,530	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,562	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	4,868	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	827,837	201,080	70,044	0	166	30.00
31.00	03100	INTENSIVE CARE UNIT	94,589	42,058	14,651	0	9	31.00
43.00	04300	NURSERY	0	6,504	2,266	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	100,998	35,182	0	492	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,290	798	0	5,303	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,864	0	0	6	54.00
54.01	03630	ULTRASOUND	0	0	0	0	54	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	20,685	7,205	0	0	55.00
55.01	05501	CYBERKNIFE	0	0	0	0	0	55.01
56.00	05600	RADIO SOTOPE	0	3,737	0	0	29,363	56.00
57.00	05700	CT SCAN	0	6,415	0	0	1,607	57.00
58.00	05800	MRI	0	4,758	0	0	11	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,164	0	0	0	59.00
60.00	06000	LABORATORY	0	68,312	0	0	24,263	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	19,357	0	0	79	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	26,514	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,606	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,442	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,358	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,705	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	689,369	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	54	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,344	1,165	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	231,962	0	0	115,910	90.00
90.01	09001	OUTPATIENT CLINICS	0	18,602	6,480	0	214	90.01
90.02	09003	OUTPATIENT SERVICES	0	4,646	1,618	0	0	90.02
91.00	09100	EMERGENCY	0	50,389	17,553	0	2,422	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)	922,426	931,452	156,962	0	869,322	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,189	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,040	0	0	0	192.00
192.01	19201	SCHOOL NURSES	0	10,675	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	2,031	0	0	37,208	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	922,426	951,387	156,962	0	906,530	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

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

Worksheet B
Part II
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM-PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	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	258,431				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	0	152,622		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,577	0		14,374,366	0 30.00
31.00	03100	INTENSIVE CARE UNIT	4,904	0		2,086,834	0 31.00
43.00	04300	NURSERY	1,563	0		57,116	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,267	0		6,097,624	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,376	0		144,062	0 52.00
53.00	05300	ANESTHESIOLOGY	10,047	0		125,969	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,319	0		1,763,812	0 54.00
54.01	03630	ULTRASOUND	3,583	0		287,775	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	4,281	0		2,517,517	0 55.00
55.01	05501	CYBERKNIFE	1,591	0		79,763	0 55.01
56.00	05600	RADIOISOTOPE	2,159	0		341,814	0 56.00
57.00	05700	CT SCAN	16,252	0		331,191	0 57.00
58.00	05800	MRI	5,925	0		414,863	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	6,272	0		1,365,472	0 59.00
60.00	06000	LABORATORY	22,625	0		2,435,078	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0 62.30
65.00	06500	RESPIRATORY THERAPY	3,617	0		473,432	0 65.00
65.01	03610	SLEEP LAB	774	0		41,878	0 65.01
66.00	06600	PHYSICAL THERAPY	2,892	0		242,240	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	602	0		111,979	0 67.00
68.00	06800	SPEECH PATHOLOGY	259	0		9,917	0 68.00
69.00	06900	ELECTROCARDIOLOGY	3,535	0		737,230	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	553	0		12,244	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,608	0		716,693	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,689	0		1,030,686	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,658	0		1,005,667	0 73.00
74.00	07400	RENAL DIALYSIS	326	0		68,579	0 74.00
76.00	03020	CARDIAC REHABILITATION	0	0		0	0 76.00
76.97	07697	CARDIAC REHABILITATION	383	0		48,779	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		0	0 76.98
76.99	07699	LITHOTRIPSY	0	0		0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,562	0		1,845,911	0 90.00
90.01	09001	OUTPATIENT CLINICS	1,300	0		170,631	0 90.01
90.02	09003	OUTPATIENT SERVICES	546	0		314,717	0 90.02
91.00	09100	EMERGENCY	20,386	0		2,134,034	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)	258,431	0	0	41,387,873	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		389,001	0 190.00
190.01	19001	FOUNDATION	0	0		13,102	0 190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		501,893	0 192.00
192.01	19201	SCHOOL NURSES	0	0		43,155	0 192.01
194.00	07950	OUTPATIENT PHARMACY	0	0		91,879	0 194.00
200.00		Cross Foot Adjustments			152,622	152,622	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	258,431	0	152,622	42,579,525	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/21/2017 1:01 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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
23.00	02300	PARAMED PRGM-PASTORAL CARE	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
55.01	05501	CYBERKNIFE	55.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	03610	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	CARDIAC REHABILITATION	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT CLINICS	90.01
90.02	09003	OUTPATIENT SERVICES	90.02
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
190.01	19001	FOUNDATION	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SCHOOL NURSES	192.01
194.00	07950	OUTPATIENT PHARMACY	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118-201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	661,709				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		10,215,829			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,933	19,266	135,818,329		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	86,175	3,455,607	10,749,062	-100,037,919	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	34,280	869,266	2,625,552	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,632	20,693	553,835	0	8.00
9.00 00900	HOUSEKEEPING	1,508	25,809	3,669,405	0	9.00
10.00 01000	DIETARY	12,854	150,915	1,164,136	0	10.00
11.00 01100	CAFETERIA	18,028	0	1,452,893	0	11.00
13.00 01300	NURSING ADMINISTRATION	882	3,822	2,893,103	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00 01500	PHARMACY	2,512	89,023	3,369,553	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,827	27,917	1,151,122	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00 02300	PARAMED PRGM-PASTORAL CARE	2,600	81	406,284	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	222,147	822,470	21,667,409	0	30.00
31.00 03100	INTENSIVE CARE UNIT	31,344	80,842	6,063,071	0	31.00
43.00 04300	NURSERY	0	0	1,393,807	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	63,162	1,537,238	12,538,115	0	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	3,478,403	0	52.00
53.00 05300	ANESTHESIOLOGY	396	54,653	190,754	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,605	454,826	3,778,431	0	54.00
54.01 03630	ULTRASOUND	1,808	103,874	1,461,389	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	30,100	619,274	2,804,367	0	55.00
55.01 05501	CYBERKNIFE	0	0	564,688	0	55.01
56.00 05600	RADIOISOTOPE	4,148	27,722	643,746	0	56.00
57.00 05700	CT SCAN	2,683	92,443	1,059,702	0	57.00
58.00 05800	MRI	2,776	167,719	814,570	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	12,496	485,116	1,348,734	0	59.00
60.00 06000	LABORATORY	29,394	390,706	7,075,703	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	6,316	42,040	1,868,620	0	65.00
65.01 03610	SLEEP LAB	0	17,258	483,780	0	65.01
66.00 06600	PHYSICAL THERAPY	1,612	11,340	3,388,523	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,610	2,776	636,284	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	243,887	0	68.00
69.00 06900	ELECTROCARDIOLOGY	11,223	88,317	901,729	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	297,596	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	880	497	0	0	74.00
76.00 03020	CARDIAC REHABILITATION	0	0	0	0	76.00
76.97 07697	CARDIAC REHABILITATION	0	21,088	442,592	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	394,575	22,921,887	0	90.00
90.01 09001	OUTPATIENT CLINICS	0	33,109	2,832,226	0	90.01
90.02 09003	OUTPATIENT SERVICES	5,132	19,002	500,583	0	90.02
91.00 09100	EMERGENCY	33,021	78,178	6,219,526	0	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)	647,084	10,207,462	133,655,067	-100,037,919	317,312,116
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,608	8,367	364,192	0	190.00
190.01 19001	FOUNDATION	0	0	382,777	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	8,017	0	137,156	0	192.00
192.01 19201	SCHOOL NURSES	0	0	966,529	0	192.01
194.00 07950	OUTPATIENT PHARMACY	0	0	312,608	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	28,990,357	13,589,168	29,026,725		100,037,919

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	43.811339	1.330207	0.213717		0.308786	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			285,561		8,394,718	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002103		0.025912	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1
Date/Time Prepared:
11/21/2017 1:01 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	0					6.00
7.00	00700		535,321				7.00
8.00	00800		1,632	3,863,915			8.00
9.00	00900	0	1,508	29,212	532,181		9.00
10.00	01000	0	12,854	0	12,854	180,995	10.00
11.00	01100	0	18,028	0	18,028	0	11.00
13.00	01300	0	882	0	882	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	2,512	0	2,512	0	15.00
16.00	01600	0	1,827	0	1,827	0	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	0	2,600	0	2,600	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	222,147	762,813	222,147	162,435	30.00
31.00	03100	0	31,344	201,922	31,344	18,560	31.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	63,162	364,206	63,162	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	396	0	396	0	53.00
54.00	05400	0	18,605	144,366	18,605	0	54.00
54.01	03630	0	1,808	2,150	1,808	0	54.01
55.00	05500	0	30,100	5,577	30,100	0	55.00
55.01	05501	0	0	0	0	0	55.01
56.00	05600	0	4,148	28,205	4,148	0	56.00
57.00	05700	0	2,683	18,869	2,683	0	57.00
58.00	05800	0	2,776	49,429	2,776	0	58.00
59.00	05900	0	12,496	52,429	12,496	0	59.00
60.00	06000	0	29,394	684	29,394	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	6,316	0	6,316	0	65.00
65.01	03610	0	0	9,454	0	0	65.01
66.00	06600	0	1,612	8,123	1,612	0	66.00
67.00	06700	0	1,610	0	1,610	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	11,223	0	11,223	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	880	4,477	880	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	0	0	1,119	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	34,652	0	0	90.00
90.01	09001	0	0	43,390	0	0	90.01
90.02	09003	0	5,132	17,623	5,132	0	90.02
91.00	09100	0	33,021	353,946	33,021	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		0	520,696	2,132,646	517,556	180,995	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	6,608	20,972	6,608	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	8,017	1,710,297	8,017	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		0	23,726,307	1,307,748	7,307,723	4,510,797	202.00
203.00		0.000000	44.321644	0.338452	13.731650	24.922219	203.00
204.00		0	3,133,424	134,203	261,120	922,426	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		6.00	7.00	8.00	9.00	10.00	205.00
		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	5.853355	0.034732	0.490660	5.096417	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		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	3,720,025					11.00
13.00	01300	42,565	1,761,881				13.00
14.00	01400	0	0	0			14.00
15.00	01500	79,555	0	0	39,162,456		15.00
16.00	01600	68,668	0	0	0	2,283,113,918	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	19,036	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	786,245	786,245	0	7,161	208,648,583	30.00
31.00	03100	164,451	164,451	0	374	43,398,482	31.00
43.00	04300	25,431	25,431	0	0	13,827,656	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	394,914	394,914	0	21,234	214,756,608	50.00
52.00	05200	0	0	0	0	29,879,498	52.00
53.00	05300	8,956	8,956	0	229,079	88,910,658	53.00
54.00	05400	175,422	0	0	270	73,618,815	54.00
54.01	03630	0	0	0	2,337	31,707,122	54.01
55.00	05500	80,880	80,880	0	4	37,883,881	55.00
55.01	05501	0	0	0	0	14,078,771	55.01
56.00	05600	14,614	0	0	1,268,479	19,106,018	56.00
57.00	05700	25,083	0	0	69,435	143,821,192	57.00
58.00	05800	18,606	0	0	458	52,436,321	58.00
59.00	05900	31,921	0	0	0	55,501,854	59.00
60.00	06000	267,106	0	0	1,048,166	200,225,293	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	75,689	0	0	3,399	32,006,733	65.00
65.01	03610	0	0	0	0	6,849,879	65.01
66.00	06600	103,672	0	0	0	25,593,022	66.00
67.00	06700	14,101	0	0	0	5,327,085	67.00
68.00	06800	5,640	0	0	0	2,288,192	68.00
69.00	06900	24,861	0	0	0	31,284,740	69.00
70.00	07000	6,668	0	0	0	4,897,709	70.00
71.00	07100	0	0	0	0	111,574,631	71.00
72.00	07200	0	0	0	0	138,843,754	72.00
73.00	07300	0	0	0	29,781,148	409,009,891	73.00
74.00	07400	0	0	0	2,328	2,881,584	74.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	13,077	13,077	0	7	3,389,430	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	906,988	0	0	5,007,329	84,619,201	90.00
90.01	09001	72,735	72,735	0	9,234	11,508,580	90.01
90.02	09003	18,165	18,165	0	0	4,827,701	90.02
91.00	09100	197,027	197,027	0	104,635	180,411,034	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,642,076	1,761,881	0	37,555,077	2,283,113,918	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	20,288	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	7,976	0	0	0	0	192.00
192.01	19201	41,742	0	0	0	0	192.01
194.00	07950	7,943	0	0	1,607,379	0	194.00
200.00							200.00
201.00							201.00
202.00		3,275,588	4,668,329	0	32,273,266	5,706,331	202.00
203.00		0.880528	2.649628	0.000000	0.824087	0.002499	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	951,387	156,962	0	906,530	258,431	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.255747	0.089088	0.000000	0.023148	0.000113	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMED PRGM-PASTORAL CARE (ASSIGNED TIME)	
		17.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	0 317	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0 184	30.00
31.00	03100	INTENSIVE CARE UNIT	0 50	31.00
43.00	04300	NURSERY	0 0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0 0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0 0	52.00
53.00	05300	ANESTHESIOLOGY	0 0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0 0	54.00
54.01	03630	ULTRASOUND	0 0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0 0	55.00
55.01	05501	CYBERKNIFE	0 0	55.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0 0	62.30
65.00	06500	RESPIRATORY THERAPY	0 0	65.00
65.01	03610	SLEEP LAB	0 0	65.01
66.00	06600	PHYSICAL THERAPY	0 0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0 0	67.00
68.00	06800	SPEECH PATHOLOGY	0 0	68.00
69.00	06900	ELECTROCARDIOLOGY	0 0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0 0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0 0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0 0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0 0	73.00
74.00	07400	RENAL DIALYSIS	0 0	74.00
76.00	03020	CARDIAC REHABILITATION	0 0	76.00
76.97	07697	CARDIAC REHABILITATION	0 0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0 0	76.98
76.99	07699	LITHOTRIPSY	0 0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0 0	90.00
90.01	09001	OUTPATIENT CLINICS	0 33	90.01
90.02	09003	OUTPATIENT SERVICES	0 0	90.02
91.00	09100	EMERGENCY	0 50	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)	0 317	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0	190.00
190.01	19001	FOUNDATION	0 0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0 0	192.00
192.01	19201	SCHOOL NURSES	0 0	192.01
194.00	07950	OUTPATIENT PHARMACY	0 0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0 995,438	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000 3,140.182965	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMED PRGM-PASTORAL CARE (ASSIGNED TIME)	
204.00	Cost to be allocated (per Wkst. B, Part II)	17.00	23.00	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	152,622 481.457413	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/21/2017 1:01 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Dissallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		68,748,002	0	68,748,002
31.00	03100 INTENSIVE CARE UNIT		14,877,124	0	14,877,124
43.00	04300 NURSERY		2,339,239	0	2,339,239
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		40,332,306	0	40,332,306
52.00	05200 DELIVERY ROOM & LABOR ROOM		6,811,069	0	6,811,069
53.00	05300 ANESTHESIOLOGY		1,201,422	0	1,201,422
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,524,237	0	9,524,237
54.01	03630 ULTRASOUND		2,820,135	0	2,820,135
55.00	05500 RADIOLOGY-THERAPEUTIC		9,494,454	0	9,494,454
55.01	05501 CYBERKNIFE		3,923,538	0	3,923,538
56.00	05600 RADIOISOTOPE		4,351,522	0	4,351,522
57.00	05700 CT SCAN		2,949,402	0	2,949,402
58.00	05800 MRI		2,265,554	0	2,265,554
59.00	05900 CARDIAC CATHETERIZATION		4,664,442	0	4,664,442
60.00	06000 LABORATORY		19,013,620	0	19,013,620
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0
65.00	06500 RESPIRATORY THERAPY	0	4,240,946	0	4,240,946
65.01	03610 SLEEP LAB	0	868,975	0	868,975
66.00	06600 PHYSICAL THERAPY	0	5,781,767	0	5,781,767
67.00	06700 OCCUPATIONAL THERAPY	0	1,229,906	0	1,229,906
68.00	06800 SPEECH PATHOLOGY	0	399,735	0	399,735
69.00	06900 ELECTROCARDIOLOGY		3,027,897	8,005	3,035,902
70.00	07000 ELECTROENCEPHALOGRAPHY		490,851	0	490,851
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		35,841,387	0	35,841,387
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		51,614,949	0	51,614,949
73.00	07300 DRUGS CHARGED TO PATIENTS		39,184,391	0	39,184,391
74.00	07400 RENAL DIALYSIS		1,235,846	0	1,235,846
76.00	03020 CARDIAC REHABILITATION		0	0	0
76.97	07697 CARDIAC REHABILITATION		805,871	0	805,871
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0
76.99	07699 LI THOTRI PSY		0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		51,326,924	211,326	51,538,250
90.01	09001 OUTPATIENT CLINICS		5,085,030	0	5,085,030
90.02	09003 OUTPATIENT SERVICES		1,570,494	0	1,570,494
91.00	09100 EMERGENCY		16,444,473	0	16,444,473
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		6,060,747	0	6,060,747
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)	0	418,526,255	219,331	418,745,586
201.00	Less Observation Beds		6,060,747		6,060,747
202.00	Total (see instructions)	0	412,465,508	219,331	412,684,839

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/21/2017 1:01 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	192,873,877		192,873,877				30.00
31.00	03100	INTENSIVE CARE UNIT	43,398,482		43,398,482				31.00
43.00	04300	NURSERY	13,827,656		13,827,656				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	119,584,062	95,172,546	214,756,608	0.187805	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,776,383	4,103,115	29,879,498	0.227951	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	50,279,169	38,631,489	88,910,658	0.013513	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,525,834	52,092,981	73,618,815	0.129372	0.000000		54.00
54.01	03630	ULTRASOUND	5,273,991	26,433,131	31,707,122	0.088943	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	277,539	37,606,342	37,883,881	0.250620	0.000000		55.00
55.01	05501	CYBERKNIFE	20,682	14,058,089	14,078,771	0.278685	0.000000		55.01
56.00	05600	RADIOISOTOPE	4,581,679	14,524,339	19,106,018	0.227757	0.000000		56.00
57.00	05700	CT SCAN	36,550,242	107,270,950	143,821,192	0.020507	0.000000		57.00
58.00	05800	MRI	9,798,904	42,637,417	52,436,321	0.043206	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	22,457,714	33,044,140	55,501,854	0.084041	0.000000		59.00
60.00	06000	LABORATORY	58,918,674	141,306,619	200,225,293	0.094961	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	29,179,794	2,826,939	32,006,733	0.132502	0.000000		65.00
65.01	03610	SLEEP LAB	3,972	6,845,907	6,849,879	0.126860	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	10,518,898	15,074,124	25,593,022	0.225912	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,810,177	1,516,908	5,327,085	0.230878	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,216,721	71,471	2,288,192	0.174695	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	13,267,638	18,017,102	31,284,740	0.096785	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,058,022	839,687	4,897,709	0.100221	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,282,593	42,292,038	111,574,631	0.321232	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,707,572	33,136,182	138,843,754	0.371748	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	223,401,566	185,608,325	409,009,891	0.095803	0.000000		73.00
74.00	07400	RENAL DIALYSIS	2,770,701	110,883	2,881,584	0.428877	0.000000		74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	370,698	3,018,732	3,389,430	0.237760	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	288,821	84,330,380	84,619,201	0.606564	0.000000		90.00
90.01	09001	OUTPATIENT CLINICS	578,343	10,930,237	11,508,580	0.441847	0.000000		90.01
90.02	09003	OUTPATIENT SERVICES	0	4,827,701	4,827,701	0.325309	0.000000		90.02
91.00	09100	EMERGENCY	51,035,883	129,375,151	180,411,034	0.091150	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,066,499	12,708,207	15,774,706	0.384207	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	1,124,702,786	1,158,411,132	2,283,113,918				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	1,124,702,786	1,158,411,132	2,283,113,918				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/21/2017 1:01 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
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.187805		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.227951		52.00
53.00	05300 ANESTHESIOLOGY	0.013513		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.129372		54.00
54.01	03630 ULTRASOUND	0.088943		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.250620		55.00
55.01	05501 CYBERKNIFE	0.278685		55.01
56.00	05600 RADIOISOTOPE	0.227757		56.00
57.00	05700 CT SCAN	0.020507		57.00
58.00	05800 MRI	0.043206		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.084041		59.00
60.00	06000 LABORATORY	0.094961		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.132502		65.00
65.01	03610 SLEEP LAB	0.126860		65.01
66.00	06600 PHYSICAL THERAPY	0.225912		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.230878		67.00
68.00	06800 SPEECH PATHOLOGY	0.174695		68.00
69.00	06900 ELECTROCARDIOLOGY	0.097041		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.100221		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.321232		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.371748		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.095803		73.00
74.00	07400 RENAL DIALYSIS	0.428877		74.00
76.00	03020 CARDIAC REHABILITATION	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.237760		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.609061		90.00
90.01	09001 OUTPATIENT CLINICS	0.441847		90.01
90.02	09003 OUTPATIENT SERVICES	0.325309		90.02
91.00	09100 EMERGENCY	0.091150		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.384207		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: 14-0200

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

Worksheet C
Part I
Date/Time Prepared:
11/21/2017 1:01 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	68,748,002		68,748,002	0	68,748,002	30.00
31.00	03100 INTENSIVE CARE UNIT	14,877,124		14,877,124	0	14,877,124	31.00
43.00	04300 NURSERY	2,339,239		2,339,239	0	2,339,239	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	40,332,306		40,332,306	0	40,332,306	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,811,069		6,811,069	0	6,811,069	52.00
53.00	05300 ANESTHESIOLOGY	1,201,422		1,201,422	0	1,201,422	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	9,524,237		9,524,237	0	9,524,237	54.00
54.01	03630 ULTRASOUND	2,820,135		2,820,135	0	2,820,135	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	9,494,454		9,494,454	0	9,494,454	55.00
55.01	05501 CYBERKNIFE	3,923,538		3,923,538	0	3,923,538	55.01
56.00	05600 RADIOISOTOPE	4,351,522		4,351,522	0	4,351,522	56.00
57.00	05700 CT SCAN	2,949,402		2,949,402	0	2,949,402	57.00
58.00	05800 MRI	2,265,554		2,265,554	0	2,265,554	58.00
59.00	05900 CARDIAC CATHETERIZATION	4,664,442		4,664,442	0	4,664,442	59.00
60.00	06000 LABORATORY	19,013,620		19,013,620	0	19,013,620	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	4,240,946	0	4,240,946	0	4,240,946	65.00
65.01	03610 SLEEP LAB	868,975	0	868,975	0	868,975	65.01
66.00	06600 PHYSICAL THERAPY	5,781,767	0	5,781,767	0	5,781,767	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,229,906	0	1,229,906	0	1,229,906	67.00
68.00	06800 SPEECH PATHOLOGY	399,735	0	399,735	0	399,735	68.00
69.00	06900 ELECTROCARDIOLOGY	3,027,897		3,027,897	8,005	3,035,902	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	490,851		490,851	0	490,851	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35,841,387		35,841,387	0	35,841,387	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	51,614,949		51,614,949	0	51,614,949	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	39,184,391		39,184,391	0	39,184,391	73.00
74.00	07400 RENAL DIALYSIS	1,235,846		1,235,846	0	1,235,846	74.00
76.00	03020 CARDIAC REHABILITATION	0		0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	805,871		805,871	0	805,871	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	51,326,924		51,326,924	211,326	51,538,250	90.00
90.01	09001 OUTPATIENT CLINICS	5,085,030		5,085,030	0	5,085,030	90.01
90.02	09003 OUTPATIENT SERVICES	1,570,494		1,570,494	0	1,570,494	90.02
91.00	09100 EMERGENCY	16,444,473		16,444,473	0	16,444,473	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6,060,747		6,060,747	0	6,060,747	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	418,526,255	0	418,526,255	219,331	418,745,586	200.00
201.00	Less Observation Beds	6,060,747		6,060,747		6,060,747	201.00
202.00	Total (see instructions)	412,465,508	0	412,465,508	219,331	412,684,839	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/21/2017 1:01 pm		
			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	192,873,877		192,873,877				30.00
31.00	03100	INTENSIVE CARE UNIT	43,398,482		43,398,482				31.00
43.00	04300	NURSERY	13,827,656		13,827,656				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	119,584,062	95,172,546	214,756,608	0.187805	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,776,383	4,103,115	29,879,498	0.227951	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	50,279,169	38,631,489	88,910,658	0.013513	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,525,834	52,092,981	73,618,815	0.129372	0.000000		54.00
54.01	03630	ULTRASOUND	5,273,991	26,433,131	31,707,122	0.088943	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	277,539	37,606,342	37,883,881	0.250620	0.000000		55.00
55.01	05501	CYBERKNIFE	20,682	14,058,089	14,078,771	0.278685	0.000000		55.01
56.00	05600	RADIOISOTOPE	4,581,679	14,524,339	19,106,018	0.227757	0.000000		56.00
57.00	05700	CT SCAN	36,550,242	107,270,950	143,821,192	0.020507	0.000000		57.00
58.00	05800	MRI	9,798,904	42,637,417	52,436,321	0.043206	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	22,457,714	33,044,140	55,501,854	0.084041	0.000000		59.00
60.00	06000	LABORATORY	58,918,674	141,306,619	200,225,293	0.094961	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	29,179,794	2,826,939	32,006,733	0.132502	0.000000		65.00
65.01	03610	SLEEP LAB	3,972	6,845,907	6,849,879	0.126860	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	10,518,898	15,074,124	25,593,022	0.225912	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,810,177	1,516,908	5,327,085	0.230878	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	2,216,721	71,471	2,288,192	0.174695	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	13,267,638	18,017,102	31,284,740	0.096785	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,058,022	839,687	4,897,709	0.100221	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	69,282,593	42,292,038	111,574,631	0.321232	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,707,572	33,136,182	138,843,754	0.371748	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	223,401,566	185,608,325	409,009,891	0.095803	0.000000		73.00
74.00	07400	RENAL DIALYSIS	2,770,701	110,883	2,881,584	0.428877	0.000000		74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	370,698	3,018,732	3,389,430	0.237760	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	288,821	84,330,380	84,619,201	0.606564	0.000000		90.00
90.01	09001	OUTPATIENT CLINICS	578,343	10,930,237	11,508,580	0.441847	0.000000		90.01
90.02	09003	OUTPATIENT SERVICES	0	4,827,701	4,827,701	0.325309	0.000000		90.02
91.00	09100	EMERGENCY	51,035,883	129,375,151	180,411,034	0.091150	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,066,499	12,708,207	15,774,706	0.384207	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	1,124,702,786	1,158,411,132	2,283,113,918				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	1,124,702,786	1,158,411,132	2,283,113,918				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/21/2017 1:01 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
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
54.01	03630	ULTRASOUND	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
55.01	05501	CYBERKNIFE	0.000000	55.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
65.01	03610	SLEEP LAB	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03020	CARDIAC REHABILITATION	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	OUTPATIENT CLINICS	0.000000	90.01
90.02	09003	OUTPATIENT SERVICES	0.000000	90.02
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: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part I Date/Time Prepared: 11/21/2017 1:01 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	14,374,366	0	14,374,366	63,000	228.16	30.00
31.00	INTENSIVE CARE UNIT	2,086,834		2,086,834	9,924	210.28	31.00
43.00	NURSERY	57,116		57,116	5,717	9.99	43.00
200.00	Total (Lines 30-199)	16,518,316		16,518,316	78,641		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	27,602	6,297,672				
31.00	INTENSIVE CARE UNIT	2,100	441,588				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	29,702	6,739,260				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0200

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

Worksheet D
Part II
Date/Time Prepared:
11/21/2017 1:01 pm

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	6,097,624	214,756,608	0.028393	43,677,374	1,240,132	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	144,062	29,879,498	0.004821	0	0	52.00
53.00	05300	ANESTHESIOLOGY	125,969	88,910,658	0.001417	17,776,029	25,189	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,763,812	73,618,815	0.023959	10,825,095	259,358	54.00
54.01	03630	ULTRASOUND	287,775	31,707,122	0.009076	2,450,742	22,243	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,517,517	37,883,881	0.066454	158,573	10,538	55.00
55.01	05501	CYBERKNIFE	79,763	14,078,771	0.005665	18,834	107	55.01
56.00	05600	RADIOISOTOPE	341,814	19,106,018	0.017890	2,274,904	40,698	56.00
57.00	05700	CT SCAN	331,191	143,821,192	0.002303	16,924,079	38,976	57.00
58.00	05800	MRI	414,863	52,436,321	0.007912	3,763,953	29,780	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,365,472	55,501,854	0.024602	10,792,438	265,516	59.00
60.00	06000	LABORATORY	2,435,078	200,225,293	0.012162	26,021,049	316,468	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	473,432	32,006,733	0.014792	17,904,142	264,838	65.00
65.01	03610	SLEEP LAB	41,878	6,849,879	0.006114	3,906	24	65.01
66.00	06600	PHYSICAL THERAPY	242,240	25,593,022	0.009465	5,459,341	51,673	66.00
67.00	06700	OCCUPATIONAL THERAPY	111,979	5,327,085	0.021021	2,021,978	42,504	67.00
68.00	06800	SPEECH PATHOLOGY	9,917	2,288,192	0.004334	1,319,426	5,718	68.00
69.00	06900	ELECTROCARDIOLOGY	737,230	31,284,740	0.023565	6,457,566	152,173	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,244	4,897,709	0.002500	1,721,847	4,305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	716,693	111,574,631	0.006423	27,585,887	177,184	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,030,686	138,843,754	0.007423	38,491,654	285,724	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,005,667	409,009,891	0.002459	91,805,693	225,750	73.00
74.00	07400	RENAL DIALYSIS	68,579	2,881,584	0.023799	1,571,430	37,398	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	48,779	3,389,430	0.014392	178,883	2,574	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,845,911	84,619,201	0.021814	158,291	3,453	90.00
90.01	09001	OUTPATIENT CLINICS	170,631	11,508,580	0.014826	292,068	4,330	90.01
90.02	09003	OUTPATIENT SERVICES	314,717	4,827,701	0.065190	0	0	90.02
91.00	09100	EMERGENCY	2,134,034	180,411,034	0.011829	23,333,165	276,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,267,229	15,774,706	0.080333	803,115	64,517	92.00
200.00		Total (Lines 50-199)	26,136,786	2,033,013,903		353,791,462	3,847,178	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/21/2017 1:01 pm	
Cost Center Description			Title XVIII		Hospital		PPS	
			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	577,794	0	0	577,794	30.00
31.00	03100	INTENSIVE CARE UNIT	0	157,009	0	0	157,009	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	734,803	0	0	734,803	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)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	63,000	9.17	27,602	253,110		30.00
31.00	03100	INTENSIVE CARE UNIT	9,924	15.82	2,100	33,222		31.00
43.00	04300	NURSERY	5,717	0.00	0	0		43.00
200.00		Total (lines 30-199)	78,641		29,702	286,332		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/21/2017 1:01 pm
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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	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
55.01	05501	CYBERKNIFE	0	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT CLINICS	0	0	103,626	0	103,626	0	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	157,009	0	157,009	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	50,941	0	50,941	0	92.00
200.00		Total (lines 50-199)	0	0	311,576	0	311,576	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/21/2017 1:01 pm
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Cost Center Description		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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	214,756,608	0.000000	0.000000	43,677,374	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,879,498	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	88,910,658	0.000000	0.000000	17,776,029	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,618,815	0.000000	0.000000	10,825,095	54.00
54.01	03630	ULTRASOUND	0	31,707,122	0.000000	0.000000	2,450,742	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	37,883,881	0.000000	0.000000	158,573	55.00
55.01	05501	CYBERKNIFE	0	14,078,771	0.000000	0.000000	18,834	55.01
56.00	05600	RADIOISOTOPE	0	19,106,018	0.000000	0.000000	2,274,904	56.00
57.00	05700	CT SCAN	0	143,821,192	0.000000	0.000000	16,924,079	57.00
58.00	05800	MRI	0	52,436,321	0.000000	0.000000	3,763,953	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	55,501,854	0.000000	0.000000	10,792,438	59.00
60.00	06000	LABORATORY	0	200,225,293	0.000000	0.000000	26,021,049	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	32,006,733	0.000000	0.000000	17,904,142	65.00
65.01	03610	SLEEP LAB	0	6,849,879	0.000000	0.000000	3,906	65.01
66.00	06600	PHYSICAL THERAPY	0	25,593,022	0.000000	0.000000	5,459,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,327,085	0.000000	0.000000	2,021,978	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,288,192	0.000000	0.000000	1,319,426	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,284,740	0.000000	0.000000	6,457,566	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,897,709	0.000000	0.000000	1,721,847	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	111,574,631	0.000000	0.000000	27,585,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138,843,754	0.000000	0.000000	38,491,654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	409,009,891	0.000000	0.000000	91,805,693	73.00
74.00	07400	RENAL DIALYSIS	0	2,881,584	0.000000	0.000000	1,571,430	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,389,430	0.000000	0.000000	178,883	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	84,619,201	0.000000	0.000000	158,291	90.00
90.01	09001	OUTPATIENT CLINICS	103,626	11,508,580	0.009004	0.009004	292,068	90.01
90.02	09003	OUTPATIENT SERVICES	0	4,827,701	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	157,009	180,411,034	0.000870	0.000870	23,333,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	50,941	15,774,706	0.003229	0.003229	803,115	92.00
200.00		Total (Lines 50-199)	311,576	2,033,013,903			353,791,462	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/21/2017 1:01 pm
Title XVIII		Hospital	PPS

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)	
ANCILLARY SERVICE COST CENTERS			11.00	12.00	13.00	
50.00	05000	OPERATING ROOM	0	18,571,921	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	7,009,549	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,897,480	0	54.00
54.01	03630	ULTRASOUND	0	4,637,982	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,433,093	0	55.00
55.01	05501	CYBERKNIFE	0	6,105,495	0	55.01
56.00	05600	RADIOISOTOPE	0	4,663,653	0	56.00
57.00	05700	CT SCAN	0	28,610,363	0	57.00
58.00	05800	MRI	0	10,121,239	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	15,098,990	0	59.00
60.00	06000	LABORATORY	0	15,091,628	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	614,982	0	65.00
65.01	03610	SLEEP LAB	0	1,277,004	0	65.01
66.00	06600	PHYSICAL THERAPY	0	492,868	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	29,978	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,623	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,065,208	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	259,315	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,241,123	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,223,532	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,787,510	0	73.00
74.00	07400	RENAL DIALYSIS	0	67,512	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,378,402	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	17,047,238	0	90.00
90.01	09001	OUTPATIENT CLINICS	2,630	2,187,506	19,696	90.01
90.02	09003	OUTPATIENT SERVICES	0	656,141	0	90.02
91.00	09100	EMERGENCY	20,300	23,515,786	20,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,593	3,870,596	12,498	92.00
200.00		Total (lines 50-199)	25,523	275,963,717	52,653	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/21/2017 1:01 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	0.187805	18,571,921	0	415	3,487,900
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.227951	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.013513	7,009,549	0	0	94,720
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.129372	11,897,480	0	157	1,539,201
54.01 03630 ULTRASOUND	0.088943	4,637,982	0	0	412,516
55.00 05500 RADIOLOGY-THERAPEUTIC	0.250620	12,433,093	1	750	3,115,982
55.01 05501 CYBERKNIFE	0.278685	6,105,495	0	0	1,701,510
56.00 05600 RADIOLOGY-SOFT	0.227757	4,663,653	0	89	1,062,180
57.00 05700 CT SCAN	0.020507	28,610,363	2	1,397	586,713
58.00 05800 MRI	0.043206	10,121,239	3	2,561	437,298
59.00 05900 CARDIAC CATHETERIZATION	0.084041	15,098,990	1	720	1,268,934
60.00 06000 LABORATORY	0.094961	15,091,628	10,729	0	1,433,116
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.132502	614,982	0	0	81,486
65.01 03610 SLEEP LAB	0.126860	1,277,004	0	0	162,001
66.00 06600 PHYSICAL THERAPY	0.225912	492,868	0	0	111,345
67.00 06700 OCCUPATIONAL THERAPY	0.230878	29,978	0	0	6,921
68.00 06800 SPEECH PATHOLOGY	0.174695	7,623	0	0	1,332
69.00 06900 ELECTROCARDIOLOGY	0.096785	5,065,208	0	521	490,236
70.00 07000 ELECTROENCEPHALOGRAPHY	0.100221	259,315	0	0	25,989
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.321232	11,241,123	0	0	3,611,008
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.371748	13,223,532	186	0	4,915,822
73.00 07300 DRUGS CHARGED TO PATIENTS	0.095803	60,787,510	539	460,261	5,823,626
74.00 07400 RENAL DIALYSIS	0.428877	67,512	0	0	28,954
76.00 03020 CARDIAC REHABILITATION	0.000000	0	0	0	0
76.97 07697 CARDIAC REHABILITATION	0.237760	1,378,402	0	0	327,729
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99 07699 LI THOTRIPTY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0.606564	17,047,238	290	8,940	10,340,241
90.01 09001 OUTPATIENT CLINICS	0.441847	2,187,506	3,835	913	966,543
90.02 09003 OUTPATIENT SERVICES	0.325309	656,141	866	11	213,449
91.00 09100 EMERGENCY	0.091150	23,515,786	0	48	2,143,464
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.384207	3,870,596	0	0	1,487,110
200.00 Subtotal (see instructions)		275,963,717	16,452	476,783	45,877,326
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00 Net Charges (line 200 +/- line 201)		275,963,717	16,452	476,783	45,877,326

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/21/2017 1:01 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	78		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	20		54.00
54.01 03630 ULTRASOUND	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	188		55.00
55.01 05501 CYBERKNIFE	0	0		55.01
56.00 05600 RADIOISOTOPE	0	20		56.00
57.00 05700 CT SCAN	0	29		57.00
58.00 05800 MRI	0	111		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	61		59.00
60.00 06000 LABORATORY	1,019	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
65.01 03610 SLEEP LAB	0	0		65.01
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	50		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	69	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	52	44,094		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03020 CARDIAC REHABILITATION	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	176	5,423		90.00
90.01 09001 OUTPATIENT CLINICS	1,694	403		90.01
90.02 09003 OUTPATIENT SERVICES	282	4		90.02
91.00 09100 EMERGENCY	0	4		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	3,292	50,485		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	3,292	50,485		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/21/2017 1:01 pm	
Cost Center Description			Title XIX		Hospital		Cost	
			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	577,794	0	0	577,794	30.00
31.00	03100	INTENSIVE CARE UNIT	0	157,009	0	0	157,009	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	734,803	0	0	734,803	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)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	63,000	9.17	1,671	15,323		30.00
31.00	03100	INTENSIVE CARE UNIT	9,924	15.82	210	3,322		31.00
43.00	04300	NURSERY	5,717	0.00	594	0		43.00
200.00		Total (lines 30-199)	78,641		2,475	18,645		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0200

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		Title XIX			Hospital	Cost	
		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
55.01	05501	CYBERKNIFE	0	0	0	0	55.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO 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
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	OUTPATIENT CLINICS	0	0	103,626	0	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	157,009	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	260,635	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0200

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		Title XIX			Hospital		Cost	
		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	214,756,608	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,879,498	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	88,910,658	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,618,815	0.000000	0.000000	0	54.00
54.01	03630	ULTRASOUND	0	31,707,122	0.000000	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	37,883,881	0.000000	0.000000	0	55.00
55.01	05501	CYBERKNIFE	0	14,078,771	0.000000	0.000000	0	55.01
56.00	05600	RADIOISOTOPE	0	19,106,018	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	143,821,192	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	52,436,321	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	55,501,854	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	200,225,293	0.000000	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	32,006,733	0.000000	0.000000	0	65.00
65.01	03610	SLEEP LAB	0	6,849,879	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	25,593,022	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,327,085	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,288,192	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,284,740	0.000000	0.000000	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,897,709	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	111,574,631	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	138,843,754	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	409,009,891	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	2,881,584	0.000000	0.000000	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,389,430	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	84,619,201	0.000000	0.000000	0	90.00
90.01	09001	OUTPATIENT CLINICS	103,626	11,508,580	0.009004	0.009004	0	90.01
90.02	09003	OUTPATIENT SERVICES	0	4,827,701	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	157,009	180,411,034	0.000870	0.000870	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	15,774,706	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	260,635	2,033,013,903			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0200

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

Worksheet D
Part IV
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		Title XIX			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	03630 ULTRASOUND	0	0	0		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0		55.00
55.01	05501 CYBERKNIFE	0	0	0		55.01
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
65.01	03610 SLEEP LAB	0	0	0		65.01
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.00	03020 CARDIAC REHABILITATION	0	0	0		76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 OUTPATIENT CLINICS	0	0	0		90.01
90.02	09003 OUTPATIENT SERVICES	0	0	0		90.02
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/21/2017 1:01 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)		63,000	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		63,000	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)		57,446	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)		27,602	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)		68,748,002	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)		68,748,002	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)		68,748,002	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)		1,091.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		30,120,406	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)		30,120,406	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/21/2017 1:01 pm	
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)	PPS
Title XVIII		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	14,877,124	9,924	1,499.11	2,100	3,148,131	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)					54,958,219	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					88,226,756	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)					7,025,592	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,872,701	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					10,898,293	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					77,328,463	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)					5,554	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,091.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,060,747	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/21/2017 1:01 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	14,374,366	68,748,002	0.209088	6,060,747	1,267,229	90.00
91.00	Nursing School cost	0	68,748,002	0.000000	6,060,747	0	91.00
92.00	Allied health cost	577,794	68,748,002	0.008405	6,060,747	50,941	92.00
93.00	All other Medical Education	0	68,748,002	0.000000	6,060,747	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/21/2017 1:01 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			63,000 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			63,000 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)			57,446 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,671 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)			5,717 15.00
16.00	Nursery days (title V or XIX only)			594 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)			68,748,002 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)			68,748,002 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)			68,748,002 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)			1,091.24 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,823,462 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,823,462 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/21/2017 1:01 pm	
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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	2,339,239	5,717	409.17	594	243,047	42.00
43.00	INTENSIVE CARE UNIT	14,877,124	9,924	1,499.11	210	314,813	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,381,322	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					5,554	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,091.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,060,747	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/21/2017 1:01 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)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	14,374,366	68,748,002	0.209088	6,060,747	1,267,229	90.00
91.00	Nursing School cost	0	68,748,002	0.000000	6,060,747	0	91.00
92.00	Allied health cost	577,794	68,748,002	0.008405	6,060,747	50,941	92.00
93.00	All other Medical Education	0	68,748,002	0.000000	6,060,747	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/21/2017 1:01 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		79,542,005	30.00
31.00	03100	INTENSIVE CARE UNIT		21,138,101	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.187805	43,677,374	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.227951	0	52.00
53.00	05300	ANESTHESIOLOGY	0.013513	17,776,029	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129372	10,825,095	54.00
54.01	03630	ULTRASOUND	0.088943	2,450,742	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.250620	158,573	55.00
55.01	05501	CYBERKNIFE	0.278685	18,834	55.01
56.00	05600	RADIOISOTOPE	0.227757	2,274,904	56.00
57.00	05700	CT SCAN	0.020507	16,924,079	57.00
58.00	05800	MRI	0.043206	3,763,953	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.084041	10,792,438	59.00
60.00	06000	LABORATORY	0.094961	26,021,049	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.132502	17,904,142	65.00
65.01	03610	SLEEP LAB	0.126860	3,906	65.01
66.00	06600	PHYSICAL THERAPY	0.225912	5,459,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.230878	2,021,978	67.00
68.00	06800	SPEECH PATHOLOGY	0.174695	1,319,426	68.00
69.00	06900	ELECTROCARDIOLOGY	0.097041	6,457,566	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.100221	1,721,847	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.321232	27,585,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.371748	38,491,654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.095803	91,805,693	73.00
74.00	07400	RENAL DIALYSIS	0.428877	1,571,430	74.00
76.00	03020	CARDIAC REHABILITATION	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.237760	178,883	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIpsy	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.609061	158,291	90.00
90.01	09001	OUTPATIENT CLINICS	0.441847	292,068	90.01
90.02	09003	OUTPATIENT SERVICES	0.325309	0	90.02
91.00	09100	EMERGENCY	0.091150	23,333,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.384207	803,115	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		353,791,462	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)		353,791,462	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/21/2017 1:01 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)		13,319,727	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		46,591,446	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)		3,507,149	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)		266.78	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)		1.56	30.00
31.00	Percentage of Medicaid patient days (see instructions)		10.16	31.00
32.00	Sum of lines 30 and 31		11.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/21/2017 1:01 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	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0	0	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)	63,418,322			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)		63,418,322		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		5,487,002		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		59,295		53.00
54.00	Special add-on payments for new technologies		4,143		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).		286,332		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		25,523		58.00
59.00	Total (sum of amounts on lines 49 through 58)		69,280,617		59.00
60.00	Primary payer payments		17,873		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		69,262,744		61.00
62.00	Deductibles billed to program beneficiaries		6,077,372		62.00
63.00	Coinurance billed to program beneficiaries		141,666		63.00
64.00	Allowable bad debts (see instructions)		427,244		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		277,709		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		268,199		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		63,321,415		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)		357,311		70.93
70.94	HRR adjustment amount (see instructions)		-457,359		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/21/2017 1:01 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	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	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)			63,221,367	71.00
71.01	Sequestration adjustment (see instructions)			1,264,427	71.01
72.00	Interim payments			61,712,400	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)			244,540	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			127,106	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0200

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/21/2017 1:01 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	13,319,727	0	13,319,727		13,319,727	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	46,591,446	0		46,591,446	46,591,446	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	3,507,149	0	878,963	2,628,186	3,507,149	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	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	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	63,418,322	0	14,198,690	49,219,632	63,418,322	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	63,418,322	0	14,198,690	49,219,632	63,418,322	15.00
16.00	Payment for inpatient program capital	50.00	5,487,002	0	1,247,245	4,239,757	5,487,002	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	0	1,036	3,107	4,143	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: 14-0200

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/21/2017 1:01 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	15,446,971	53,462,496	68,909,467	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	4,840,146	0	1,068,404	3,771,742	4,840,146	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	530,692	0	153,199	377,493	530,692	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	0.0240	0.0240	0.0240	0.0240		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	116,164	0	25,642	90,522	116,164	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,487,002	0	1,247,245	4,239,757	5,487,002	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: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/21/2017 1:01 pm
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		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. 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	13,319,727	13,319,727		13,319,727	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	46,591,446		46,591,446	46,591,446	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,507,149	878,963	2,628,186	3,507,149	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	63,418,322	14,198,690	49,219,632	63,418,322	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	63,418,322	14,198,690	49,219,632	63,418,322	15.00
16.00	Payment for inpatient program capital	50.00	5,487,002	1,247,245	4,239,757	5,487,002	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	1,036	3,107	4,143	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			15,446,971	53,462,496	68,909,467	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0200

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/21/2017 1:01 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	4,840,146	1,068,404	3,771,742	4,840,146	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	530,692	153,199	377,493	530,692	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	0.0240	0.0240	0.0240		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	116,164	25,642	90,522	116,164	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	5,487,002	1,247,245	4,239,757	5,487,002	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	357,311	96,578	260,733	357,311	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	-457,359	-117,223	-340,136	-457,359	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: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/21/2017 1:01 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		53,777	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		45,824,673	2.00
3.00	PPS payments		40,452,091	3.00
4.00	Outlier payment (see instructions)		438,892	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		52,653	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		53,777	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		493,235	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)		493,235	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)		493,235	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		439,458	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)		53,777	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)		40,943,636	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		971	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		8,050,576	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)		32,945,866	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)		32,945,866	30.00
31.00	Primary payer payments		13,512	31.00
32.00	Subtotal (line 30 minus line 31)		32,932,354	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)		636,938	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		414,010	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		433,647	36.00
37.00	Subtotal (see instructions)		33,346,364	37.00
38.00	MSP-LCC reconciliation amount from PS&R		52	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)		21,000	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		33,346,312	40.00
40.01	Sequestration adjustment (see instructions)		666,926	40.01
41.00	Interim payments		32,661,948	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		17,438	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0200

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

Worksheet E-1
Part I
Date/Time Prepared:
11/21/2017 1:01 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		61,326,618		32,213,722	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		338,217		400,279	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	01/24/2017	47,565	01/24/2017	47,947	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)		47,565		47,947	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)		61,712,400		32,661,948	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		244,540		17,438	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		61,956,940		32,679,386	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: 14-0200

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

Worksheet E-1
Part II
Date/Time Prepared:
11/21/2017 1:01 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	17,387	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	29,702	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	6,540	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	67,370	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	2,283,113,918	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	38,254,195	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/21/2017 1:01 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		2,381,322		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		2,381,322	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		2,381,322	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		2,381,322	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		2,381,322	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-0200

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

Worksheet G
Date/Time Prepared:
11/21/2017 1:01 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	1,198,594	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	95,326,248	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	9,849,921	0	0	0	7.00
8.00	Prepaid expenses	2,838,012	0	0	0	8.00
9.00	Other current assets	-66,043	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)	109,146,732	0	0	0	11.00
FIXED ASSETS						
12.00	Land	31,291,564	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	459,219,653	0	0	0	15.00
16.00	Accumulated depreciation	-303,099,948	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	221,824,196	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	409,235,465	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	5,208,381	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	1,287,506	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,495,887	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	524,878,084	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	11,257,200	0	0	0	37.00
38.00	Salaries, wages, and fees payable	24,337,164	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	99,288,606	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	134,882,970	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	48,054,884	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	48,054,884	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	182,937,854	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	341,940,230				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)	341,940,230	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	524,878,084	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0200

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

Worksheet G-1

Date/Time Prepared:
11/21/2017 1:01 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		311,878,345			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		11,858,945				2.00
3.00	Total (sum of line 1 and line 2)		323,737,290			0	3.00
4.00	TEMP RESTRICTED NET ASSETS	2,172,404		0		0	4.00
5.00	PERM RESTRICTED NET ASSETS	489,515		0		0	5.00
6.00	TRANSFERS	18,017,175		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		20,679,094			0	10.00
11.00	Subtotal (line 3 plus line 10)		344,416,384			0	11.00
12.00	TRANSFERS TO AFFILIATES	0		0		0	12.00
13.00	OTHER TRANSFERS	2,476,150		0		0	13.00
14.00	RECONCILING ITEM	4		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		2,476,154			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		341,940,230			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	TEMP RESTRICTED NET ASSETS		0				4.00
5.00	PERM RESTRICTED NET ASSETS		0				5.00
6.00	TRANSFERS		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	TRANSFERS TO AFFILIATES		0				12.00
13.00	OTHER TRANSFERS		0				13.00
14.00	RECONCILING ITEM		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: 14-0200

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/21/2017 1:01 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	192,873,877		192,873,877	1.00
2.00	SUBPROVIDER - IPF				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)	192,873,877		192,873,877	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	43,398,482		43,398,482	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)	43,398,482		43,398,482	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	236,272,359		236,272,359	17.00
18.00	Ancillary services	874,602,771		874,602,771	18.00
19.00	Outpatient services		1,160,095,658	1,160,095,658	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	NURSERY	13,827,656	0	13,827,656	27.00
27.01	PROFESSIONAL FEES	0	14,270,339	14,270,339	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,124,702,786	1,174,365,997	2,299,068,783	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		431,636,051		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)		431,636,051		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0200

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

Worksheet G-3

Date/Time Prepared:
11/21/2017 1:01 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,299,068,783	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,872,054,002	2.00
3.00	Net patient revenues (line 1 minus line 2)	427,014,781	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	431,636,051	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,621,270	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	517,186	6.00
7.00	Income from investments	2,160,426	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	27,912	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	2,444,672	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	REFERENCE LAB	2,695,468	24.00
24.01	MGMT FEES	430,944	24.01
24.02	RENTAL INCOME	2,056,219	24.02
24.03	IHP DISTRIBUTIONS	555,248	24.03
24.04	APN'S	0	24.04
24.05	GRANTS	151,261	24.05
24.06	SCHOOL NURSES	0	24.06
24.07	EMP LEASING	0	24.07
24.08		0	24.08
24.09	OTHER REVENUE	3,341,421	24.09
24.10	INTERCO REV	862,943	24.10
24.11		0	24.11
24.12	RESEARCH	10,865	24.12
24.13		0	24.13
24.14	OTHER COMMUNITY REV	1,225,621	24.14
24.15	OTHER (SPECIFY)	0	24.15
25.00	Total other income (sum of lines 6-24)	16,480,186	25.00
26.00	Total (line 5 plus line 25)	11,858,916	26.00
27.00	ROUNDING	-29	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-29	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,858,945	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0200	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/21/2017 1:01 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,840,146	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		530,692	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)		184.58	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)		1.56	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		10.16	8.00
9.00	Sum of lines 7 and 8		11.72	9.00
10.00	Allowable disproportionate share percentage (see instructions)		2.40	10.00
11.00	Disproportionate share adjustment (see instructions)		116,164	11.00
12.00	Total prospective capital payments (see instructions)		5,487,002	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