

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: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 10:54 am
--	-----------------------	---------------------------------------	--

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 5/29/2018 Time: 10:54 am
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. Initial Report for this Provider CCN 12. If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. Final Report for this Provider CCN number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE SAINT JOSEPH HOSPITAL ELGIN (14-0217) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) KEVIN LARKIN
 Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
 Title

05/29/2018 10:54:01 AM
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	378,894	157,302	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	18,952	-282		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	397,846	157,020	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 10:52 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 77 NORTH AIRLITE ST.			PO Box:							1.00	
2.00	City: ELGIN			State: IL		Zip Code: 60123		County: KANE			2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		PRESENCE SAINT JOSEPH HOSPITAL ELGIN		140217	20994	1	09/01/1966	N	P	P	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF		PRESENCE SAINT JOSEPH REHAB UNIT		14T217	16974	5	09/01/1997	N	P	N	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)						01/01/2017	12/31/2017		20.00		
21.00	Type of Control (see instructions)						1		21.00			
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						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	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.			2,922	1,226	0	0	815	178	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	49	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 10:52 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N			37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00	
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00	
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 10:52 am		
	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 10:52 am	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		0.00	0.00	0.000000		66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 10:52 am		
			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
			V 1.00	XIX 2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y	98.06	
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N			109.00
			1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 10:52 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	2,173,184		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.05		122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H082		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 10:52 am							
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: PRESENCE HEALTH NETWORK	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131				141.00					
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:						142.00					
143.00	City: CHICAGO	State: IL		Zip Code: 60606				143.00					
144.00 Are provider based physicians' costs included in Worksheet A?													
Y													
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													
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													
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.													
N													
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.													
N													
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.													
N													
		Part A		Part B		Title V		Title XIX					
		1.00		2.00		3.00		4.00					
155.00 Hospital													
N													
156.00 Subprovider - IPF													
N													
157.00 Subprovider - IRF													
N													
158.00 SUBPROVIDER													
N													
159.00 SNF													
N													
160.00 HOME HEALTH AGENCY													
N													
161.00 CMHC													
N													
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													
		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													
167.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.													
Y													
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													
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)													
168.01													
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)													
9.99													
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)													
01/01/2017 12/31/2017													
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)													
N													
0													

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 10:52 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			Y			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			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.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	05/11/2018	Y	05/11/2018
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: 14-0217

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

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2018 10:52 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		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.	PATRICK		GILLI LAND		41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(847)813-3718		PATRICK.GILLI LAND@PRESENCEHEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0217

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

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2018 10:52 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	129	47,085	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)		129	47,085	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		144	52,560	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	40	14,600		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		184				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,759	1,739	24,672			1.00
2.00	HMO and other (see instructions)	2,266	3,363				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	349	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)	9,759	1,739	24,672			7.00
8.00	INTENSIVE CARE UNIT	1,069	39	1,108			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)	10,828	1,778	25,780	0.00	546.32	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	11,020	7	13,008	0.00	56.57	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	602.89	27.00
28.00	Observation Bed Days		582	3,340			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
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

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

Worksheet S-3
Part I
Date/Time Prepared:
5/29/2018 10:52 am

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	2,361	1,194	5,806	1.00
2.00 HMO and other (see instructions)			473	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,361	1,194	5,806	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	1,013	1	1,204	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2018 10:52 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	39,469,483	0	39,469,483	1,254,014.79	31.47
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		4,050,944	53,319	4,104,263	126,830.24	32.36
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		3,820,455	0	3,820,455	86,136.54	44.35
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		552,810	0	552,810	4,546.00	121.60
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		9,525,866	0	9,525,866	226,449.00	42.07
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)		9,580,535	0	9,580,535		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,086,779	0	1,086,779		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		2,530,490	0	2,530,490		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	143,898	47,145	191,043	6,240.00	30.62
27.00	Administrative & General	5.00	2,200,704	1,005	2,201,709	107,265.60	20.53

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2018 10:52 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		3,599,560	0	3,599,560	19,415.00	185.40	28.00
29.00	Maintenance & Repairs	6.00	4,118	0	4,118	249.60	16.50	29.00
30.00	Operation of Plant	7.00	1,258,535	0	1,258,535	52,145.60	24.14	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,036,633	0	1,036,633	74,380.80	13.94	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	917,450	-407,739	509,711	35,583.00	14.32	34.00
35.00	Dietary under contract (see instructions)		747,724	0	747,724	12,481.00	59.91	35.00
36.00	Cafeteria	11.00	0	407,589	407,589	28,446.00	14.33	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,416,688	0	2,416,688	58,156.80	41.55	38.00
39.00	Central Services and Supply	14.00	388,187	0	388,187	18,075.20	21.48	39.00
40.00	Pharmacy	15.00	1,821,434	0	1,821,434	40,435.20	45.05	40.00
41.00	Medical Records & Medical Records Library	16.00	375,431	0	375,431	8,528.00	44.02	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2018 10:52 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	43,816,767	0	43,816,767	1,285,910.79	34.07	1.00
2.00	Excluded area salaries (see instructions)	4,050,944	53,319	4,104,263	126,830.24	32.36	2.00
3.00	Subtotal salaries (line 1 minus line 2)	39,765,823	-53,319	39,712,504	1,159,080.55	34.26	3.00
4.00	Subtotal other wages & related costs (see inst.)	13,899,131	0	13,899,131	317,131.54	43.83	4.00
5.00	Subtotal wage-related costs (see inst.)	12,111,025	0	12,111,025	0.00	30.50	5.00
6.00	Total (sum of lines 3 thru 5)	65,775,979	-53,319	65,722,660	1,476,212.09	44.52	6.00
7.00	Total overhead cost (see instructions)	14,910,362	48,000	14,958,362	461,401.80	32.42	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 5/29/2018 10:52 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,542,900 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)			1,981,749 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)			3,533,544 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			101,274 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			22,055 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)			112,027 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			474,118 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			2,773,399 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			50,418 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			75,830 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			10,667,314 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/29/2018 10:52 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		3,925,289	10,667,314
2.00	Hospital		3,820,455	9,580,535
3.00	Subprovider - IPF			
4.00	Subprovider - IRF		104,834	995,170
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis		0	0
18.00	Other		0	91,609

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/29/2018 10:52 am
---	-----------------------	---	---

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.168411	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		11,189,126	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		113,182,578	6.00
7.00	Medicaid cost (line 1 times line 6)		19,061,191	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)		7,872,065	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)		7,872,065	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)	18,466,142	1,169,716	19,635,858
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,109,901	1,169,716	4,279,617
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	3,109,901	1,169,716	4,279,617
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			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)		22,377,733	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		646,306	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		994,318	27.01
28.00	Non-Medicare bad debt expense (see instructions)		21,383,415	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,949,214	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,228,831	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		16,100,896	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet A	
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	CAP REL COSTS-BLDG & FIXT		0	0	2,881,362	2,881,362	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	4,226,424	4,226,424	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	143,898	-198,905	-55,007	43,456	-11,551	4.00
5.01	01160	COMMUNICATIONS	131,479	243,003	374,482	-15,853	358,629	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	11,023	11,023	-1,073	9,950	5.02
5.03	00570	ADMINISTRATIVE	0	0	0	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	2,069,225	31,397,999	33,467,224	-441,300	33,025,924	5.05
6.00	00600	MAINTENANCE & REPAIRS	4,118	1,998,992	2,003,110	-33,893	1,969,217	6.00
7.00	00700	OPERATION OF PLANT	1,258,535	4,788,899	6,047,434	-1,407,344	4,640,090	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	379,787	379,787	-129,207	250,580	8.00
9.00	00900	HOUSEKEEPING	1,036,633	601,836	1,638,469	-38,304	1,600,165	9.00
10.00	01000	DIETARY	917,450	1,875,865	2,793,315	-1,316,918	1,476,397	10.00
11.00	01100	CAFETERIA	0	0	0	1,240,967	1,240,967	11.00
13.00	01300	NURSING ADMINISTRATION	2,416,688	1,390,642	3,807,330	-396,610	3,410,720	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	388,187	332,710	720,897	-275,669	445,228	14.00
15.00	01500	PHARMACY	1,821,434	8,932,624	10,754,058	-8,459,285	2,294,773	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	375,431	228,206	603,637	-1,835	601,802	16.00
23.00	02300	PARAMEDICAL PRGM-AMBULANCE	203,533	96,886	300,419	46,623	347,042	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,974,761	2,951,005	11,925,766	-803,650	11,122,116	30.00
31.00	03100	INTENSIVE CARE UNIT	2,019,608	1,563,092	3,582,700	-373,950	3,208,750	31.00
41.00	04100	SUBPROVIDER - IIRF	3,758,298	4,897,432	8,655,730	-249,793	8,405,937	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,897,586	13,269,705	15,167,291	-11,780,878	3,386,413	50.00
51.00	05100	RECOVERY ROOM	1,889,915	670,760	2,560,675	-223,447	2,337,228	51.00
53.00	05300	ANESTHESIOLOGY	87,219	2,228,341	2,315,560	-178,626	2,136,934	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,223,945	2,957,158	5,181,103	-2,497,573	2,683,530	54.00
54.01	03650	VASCULAR LAB	363,710	140,822	504,532	-69,294	435,238	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	937,487	1,200,291	2,137,778	-260,394	1,877,384	55.00
57.00	05700	CT SCAN	398,016	232,499	630,515	-134,630	495,885	57.00
58.00	05800	MRI	193,017	215,437	408,454	-54,886	353,568	58.00
59.00	05900	CARDIAC CATHETERIZATION	968,512	5,015,833	5,984,345	-4,289,849	1,694,496	59.00
60.00	06000	LABORATORY	93,346	4,789,172	4,882,518	-213,776	4,668,742	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	466,270	466,270	-466,143	127	62.00
65.00	06500	RESPIRATORY THERAPY	921,761	403,596	1,325,357	-141,276	1,184,081	65.00
66.00	06600	PHYSICAL THERAPY	2,191	2,334,545	2,336,736	-28,128	2,308,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	195	932	1,127	-202	925	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,012	2,012	-1,099	913	68.00
69.00	06900	ELECTROCARDIOLOGY	530,691	211,999	742,690	-66,812	675,878	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,916,511	11,916,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,002,487	7,002,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,312,758	9,312,758	73.00
74.00	07400	RENAL DIALYSIS	0	544,444	544,444	-13,042	531,402	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	294,648	99,768	394,416	-12	394,404	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	187,597	138,296	325,893	-15,392	310,501	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	134,479	911,139	1,045,618	-173,942	871,676	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,460,966	3,539,314	6,000,280	-512,334	5,487,946	91.00
91.01	09101	CIVIL OUT	24,214	291,565	315,779	-1,700	314,079	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	251,597	146,596	398,193	-645	397,548	91.03
91.04	09104	HUNTLEY OP	0	1,631	1,631	-1,631	0	91.04
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	1,578,603	1,578,603	-1,578,603	0	113.00
118.00	11800	SUBTOTALS (SUM OF LINES 1 through 117)	39,380,370	102,881,824	142,262,194	21,590	142,283,784	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	85,522	85,522	-17,840	67,682	194.01
194.02	07952	COMMUNITY WELLNESS	89,113	19,836	108,949	-3,750	105,199	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	96	96	0	96	194.04
200.00	20000	TOTAL (SUM OF LINES 118 through 199)	39,469,483	102,987,278	142,456,761	0	142,456,761	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0217

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

Worksheet A
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,191,498	6,072,860	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	663,633	4,890,057	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	320,129	308,578	4.00
5.01	01160	COMMUNICATIONS	-20,859	337,770	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	9,950	5.02
5.03	00570	ADMINISTRATIVE	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	3,471,447	3,471,447	5.04
5.05	00590	OTHER ADMIN AND GENERAL	-5,000,530	28,025,394	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	1,969,217	6.00
7.00	00700	OPERATION OF PLANT	0	4,640,090	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	250,580	8.00
9.00	00900	HOUSEKEEPING	0	1,600,165	9.00
10.00	01000	DIETARY	0	1,476,397	10.00
11.00	01100	CAFETERIA	-541,705	699,262	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,410,720	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	288,982	734,210	14.00
15.00	01500	PHARMACY	0	2,294,773	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,368,853	1,970,655	16.00
23.00	02300	PARAMED PRGM-AMBULANCE	-49,418	297,624	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-69,202	11,052,914	30.00
31.00	03100	INTENSIVE CARE UNIT	-104,344	3,104,406	31.00
41.00	04100	SUBPROVIDER - IRF	0	8,405,937	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,386,413	50.00
51.00	05100	RECOVERY ROOM	0	2,337,228	51.00
53.00	05300	ANESTHESIOLOGY	-1,988,500	148,434	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-62,700	2,620,830	54.00
54.01	03650	VASCULAR LAB	0	435,238	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-37,835	1,839,549	55.00
57.00	05700	CT SCAN	0	495,885	57.00
58.00	05800	MRI	0	353,568	58.00
59.00	05900	CARDIAC CATHETERIZATION	-13,805	1,680,691	59.00
60.00	06000	LABORATORY	70,422	4,739,164	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	127	62.00
65.00	06500	RESPIRATORY THERAPY	0	1,184,081	65.00
66.00	06600	PHYSICAL THERAPY	0	2,308,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	925	67.00
68.00	06800	SPEECH PATHOLOGY	0	913	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,899	672,979	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,916,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,002,487	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,312,758	73.00
74.00	07400	RENAL DIALYSIS	0	531,402	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	394,404	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	310,501	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	871,676	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0	0	90.01
91.00	09100	EMERGENCY	-2,164,704	3,323,242	91.00
91.01	09101	CVILLE OUT	-296,699	17,380	91.01
91.02	09102	LAKE HILL OUT	0	0	91.02
91.03	09103	NUTRITION COUNSELING	-40,090	357,458	91.03
91.04	09104	HUNTLEY OP	0	0	91.04
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 through 117)	-1,018,326	141,265,458	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	194.00
194.01	07951	MOB	0	67,682	194.01
194.02	07952	COMMUNITY WELLNESS	0	105,199	194.02
194.03	07953	FUND DEVELOPMENT	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	96	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,018,326	141,438,435	200.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6

Date/Time Prepared:
5/29/2018 10:52 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	407,589	833,378	1.00
	O		407,589	833,378	
B - EQUIP DEPR					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,227,340	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,322,196	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
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
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
	O		0	5,549,536	
D - DIRECTLY ASSIGNED DEPR					
1.00	C'VILLE OUT	91.01	0	20,353	1.00
2.00		0.00	0	0	2.00
	O		0	20,353	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,578,603	1.00
	O		0	1,578,603	
I - EMS TRAINING COSTS					
1.00	PARAMED ED PRGM-AMBULANCE	23.00	53,319	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	O		53,319	0	
J - DEFERRED COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	47,145	0	1.00
2.00	OTHER ADMIN AND GENERAL	5.05	1,005	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
	O		48,150	0	
K - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,065,149	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

Provider CCN: 14-0217

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

Worksheet A-6

Date/Time Prepared:
5/29/2018 10:52 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
0			0	9,065,149		
L - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,002,487		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
0			0	7,002,487		
M - BILLABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	11,916,511		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
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
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6

Date/Time Prepared:
5/29/2018 10:52 am

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
				11,916,511		
N - RECLASS OP PROCEDURE COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	186,275	61,334		1.00
2.00		0.00	0	0		2.00
			186,275	61,334		
500.00	Grand Total : Increases		695,333	36,027,351		500.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6
Date/Time Prepared:
5/29/2018 10:52 am

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	407,589	833,378	0	1.00
	O		407,589	833,378		
B - EQUIP DEPR						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,022	9	1.00
2.00	COMMUNICATIONS	5.01	0	15,807	9	2.00
3.00	PURCHASING RECEIVING AND STORES	5.02	0	1,071	0	3.00
4.00	OTHER ADMIN AND GENERAL	5.05	0	438,055	0	4.00
5.00	MAINTENANCE & REPAIRS	6.00	0	33,814	0	5.00
6.00	OPERATION OF PLANT	7.00	0	1,399,423	0	6.00
7.00	HOUSEKEEPING	9.00	0	4,787	0	7.00
8.00	DIETARY	10.00	0	70,915	0	8.00
9.00	NURSING ADMINISTRATION	13.00	0	392,786	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	36,210	0	10.00
11.00	PHARMACY	15.00	0	17,301	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,835	0	12.00
13.00	PARAMED ED PRGM-AMBULANCE	23.00	0	3,715	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	0	37,317	0	14.00
15.00	INTENSIVE CARE UNIT	31.00	0	98,632	0	15.00
16.00	SUBPROVIDER - IRF	41.00	0	88,875	0	16.00
17.00	OPERATING ROOM	50.00	0	280,552	0	17.00
18.00	RECOVERY ROOM	51.00	0	1,388	0	18.00
19.00	ANESTHESIOLOGY	53.00	0	11,614	0	19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,055,000	0	20.00
21.00	VASCULAR LAB	54.01	0	6,818	0	21.00
22.00	RADIOLOGY-THERAPEUTIC	55.00	0	112,852	0	22.00
23.00	CT SCAN	57.00	0	4,086	0	23.00
24.00	MRI	58.00	0	12,058	0	24.00
25.00	CARDIAC CATHETERIZATION	59.00	0	110,648	0	25.00
26.00	LABORATORY	60.00	0	93,055	0	26.00
27.00	RESPIRATORY THERAPY	65.00	0	4,017	0	27.00
28.00	PHYSICAL THERAPY	66.00	0	10,384	0	28.00
29.00	SPEECH PATHOLOGY	68.00	0	208	0	29.00
30.00	ELECTROCARDIOLOGY	69.00	0	31,982	0	30.00
31.00	CARDIAC REHABILITATION	76.97	0	14,019	0	31.00
32.00	HYPERBARIC OXYGEN THERAPY	76.98	0	4,766	0	32.00
33.00	EMERGENCY	91.00	0	112,884	0	33.00
34.00	CVILLE OUT	91.01	0	20,353	0	34.00
35.00	MOB	194.01	0	17,656	0	35.00
36.00	HUNTLEY OP	91.04	0	1,631	0	36.00
	O		0	5,549,536		
D - DIRECTLY ASSIGNED DEPR						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	19,437	9	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	916	9	2.00
	O		0	20,353		
H - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,578,603	11	1.00
	O		0	1,578,603		
I - EMS TRAINING COSTS						
1.00	ADULTS & PEDIATRICS	30.00	1,128	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	6,646	0	0	2.00
3.00	OPERATING ROOM	50.00	2,141	0	0	3.00
4.00	ANESTHESIOLOGY	53.00	3,845	0	0	4.00
5.00	CARDIAC CATHETERIZATION	59.00	3,393	0	0	5.00
6.00	RESPIRATORY THERAPY	65.00	1,172	0	0	6.00
7.00	EMERGENCY	91.00	34,994	0	0	7.00
	O		53,319	0		
J - DEFERRED COMPENSATION						
1.00	DIETARY	10.00	150	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	13,500	0	0	2.00
3.00	OPERATING ROOM	50.00	5,000	0	0	3.00
4.00	RECOVERY ROOM	51.00	2,000	0	0	4.00
5.00	RADIOLOGY-THERAPEUTIC	55.00	2,000	0	0	5.00
6.00	CARDIAC CATHETERIZATION	59.00	25,500	0	0	6.00
	O		48,150	0		
K - DRUG COSTS						
1.00	MAINTENANCE & REPAIRS	6.00	0	69	0	1.00
2.00	OPERATION OF PLANT	7.00	0	1,602	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	890	0	3.00
4.00	PHARMACY	15.00	0	8,402,668	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	132,657	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	36,051	0	6.00
7.00	SUBPROVIDER - IRF	41.00	0	8,102	0	7.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6
Date/Time Prepared:
5/29/2018 10:52 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
8.00	OPERATING ROOM	50.00	0	40,067	0	8.00	
9.00	RECOVERY ROOM	51.00	0	69,201	0	9.00	
10.00	ANESTHESIOLOGY	53.00	0	25,662	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	14,343	0	11.00	
12.00	VASCULAR LAB	54.01	0	16,175	0	12.00	
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	17,912	0	13.00	
14.00	CT SCAN	57.00	0	56,402	0	14.00	
15.00	MRI	58.00	0	37,756	0	15.00	
16.00	CARDIAC CATHETERIZATION	59.00	0	13,169	0	16.00	
17.00	LABORATORY	60.00	0	59,326	0	17.00	
18.00	RESPIRATORY THERAPY	65.00	0	4,408	0	18.00	
19.00	PHYSICAL THERAPY	66.00	0	22	0	19.00	
20.00	ELECTROCARDIOLOGY	69.00	0	18,500	0	20.00	
21.00	RENAL DIALYSIS	74.00	0	13,042	0	21.00	
22.00	HYPERBARIC OXYGEN THERAPY	76.98	0	2,178	0	22.00	
23.00	EMERGENCY	91.00	0	94,947	0	23.00	
	O			9,065,149			
L - IMPLANTS							
1.00	HOUSEKEEPING	9.00	0	10,421	0	1.00	
2.00	DIETARY	10.00	0	70	0	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,229	0	3.00	
4.00	PARAMED ED PRGM-AMBULANCE	23.00	0	803	0	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	182	0	5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	2,125	0	6.00	
7.00	SUBPROVIDER - IRF	41.00	0	1,461	0	7.00	
8.00	OPERATING ROOM	50.00	0	6,273,986	0	8.00	
9.00	RECOVERY ROOM	51.00	0	1,379	0	9.00	
10.00	ANESTHESIOLOGY	53.00	0	1,603	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	383	0	11.00	
12.00	VASCULAR LAB	54.01	0	545	0	12.00	
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	378	0	13.00	
14.00	CT SCAN	57.00	0	14,046	0	14.00	
15.00	MRI	58.00	0	275	0	15.00	
16.00	CARDIAC CATHETERIZATION	59.00	0	623,835	0	16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	1,265	0	17.00	
18.00	HYPERBARIC OXYGEN THERAPY	76.98	0	52,407	0	18.00	
19.00	EMERGENCY	91.00	0	12,094	0	19.00	
	O			7,002,487			
M - BILLABLE SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	667	0	1.00	
2.00	COMMUNICATIONS	5.01	0	46	0	2.00	
3.00	PURCHASING RECEIVING AND STORES	5.02	0	2	0	3.00	
4.00	OTHER ADMIN AND GENERAL	5.05	0	4,250	0	4.00	
5.00	MAINTENANCE & REPAIRS	6.00	0	10	0	5.00	
6.00	OPERATION OF PLANT	7.00	0	6,319	0	6.00	
7.00	LAUNDRY & LINEN SERVICE	8.00	0	129,207	0	7.00	
8.00	HOUSEKEEPING	9.00	0	23,096	0	8.00	
9.00	DIETARY	10.00	0	4,816	0	9.00	
10.00	NURSING ADMINISTRATION	13.00	0	2,934	0	10.00	
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	234,230	0	11.00	
12.00	PHARMACY	15.00	0	39,316	0	12.00	
13.00	PARAMED ED PRGM-AMBULANCE	23.00	0	2,178	0	13.00	
14.00	ADULTS & PEDIATRICS	30.00	0	385,095	0	14.00	
15.00	INTENSIVE CARE UNIT	31.00	0	216,658	0	15.00	
16.00	SUBPROVIDER - IRF	41.00	0	151,355	0	16.00	
17.00	OPERATING ROOM	50.00	0	5,179,132	0	17.00	
18.00	RECOVERY ROOM	51.00	0	149,479	0	18.00	
19.00	ANESTHESIOLOGY	53.00	0	135,902	0	19.00	
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	427,847	0	20.00	
21.00	VASCULAR LAB	54.01	0	45,756	0	21.00	
22.00	RADIOLOGY-THERAPEUTIC	55.00	0	127,252	0	22.00	
23.00	CT SCAN	57.00	0	60,096	0	23.00	
24.00	MRI	58.00	0	4,797	0	24.00	
25.00	CARDIAC CATHETERIZATION	59.00	0	3,513,304	0	25.00	
26.00	LABORATORY	60.00	0	61,395	0	26.00	
27.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	466,143	0	27.00	
28.00	RESPIRATORY THERAPY	65.00	0	131,679	0	28.00	
29.00	PHYSICAL THERAPY	66.00	0	17,722	0	29.00	
30.00	OCCUPATIONAL THERAPY	67.00	0	202	0	30.00	
31.00	SPEECH PATHOLOGY	68.00	0	891	0	31.00	
32.00	ELECTROCARDIOLOGY	69.00	0	15,065	0	32.00	

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6

Date/Time Prepared:
5/29/2018 10:52 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
33.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	12	0	33.00
34.00	CARDIAC REHABILITATION	76.97	0	1,373	0	34.00
35.00	HYPERBARIC OXYGEN THERAPY	76.98	0	114,591	0	35.00
36.00	EMERGENCY	91.00	0	257,415	0	36.00
37.00	CIVILLE OUT	91.01	0	1,700	0	37.00
38.00	NUTRITION COUNSELING	91.03	0	645	0	38.00
39.00	MOB	194.01	0	184	0	39.00
40.00	COMMUNITY WELLNESS	194.02	0	3,750	0	40.00
			0	11,916,511		
N - RECLASS OP PROCEDURE COSTS						
1.00	ADULTS & PEDIATRICS	30.00	186,084	61,187	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	191	147	0	2.00
			186,275	61,334		
500.00	Grand Total: Decreases		695,333	36,027,351		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2018 10:52 am

		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	2,549,055	0	0	0	0	1.00
2.00	Land Improvements	1,730,493	233,946	0	233,946	0	2.00
3.00	Buildings and Fixtures	43,985,948	2,929,808	0	2,929,808	3,500	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	808,850	45,432	0	45,432	0	5.00
6.00	Movable Equipment	15,076,609	2,545,553	0	2,545,553	2,309	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	64,150,955	5,754,739	0	5,754,739	5,809	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	64,150,955	5,754,739	0	5,754,739	5,809	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,549,055	0				1.00
2.00	Land Improvements	1,964,439	0				2.00
3.00	Buildings and Fixtures	46,912,256	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	854,282	0				5.00
6.00	Movable Equipment	17,619,853	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	69,899,885	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	69,899,885	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2018 10:52 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	49,074,346	0	49,074,346	0.764982	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,076,609	0	15,076,609	0.235018	0	2.00
3.00	Total (sum of lines 1-2)	64,150,955	0	64,150,955	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	4,494,257	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,890,057	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,384,314	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,578,603	0	0	0	6,072,860	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	4,890,057	2.00
3.00	Total (sum of lines 1-2)	1,578,603	0	0	0	10,962,917	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0217

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

Worksheet A-8

Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00		3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	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	-20,859		COMMUNICATIONS	5.01	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	-5,426,793				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,484,288				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-485,275		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-20		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-13,662		CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 HOME OFFICE INTEREST INCOME			0		0.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
34.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.01
34.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.02
34.03 MISC REVENUE	B	-407,526	OTHER ADMIN AND GENERAL		5.05	0	34.03
34.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.05
34.06 MISC REVENUE	B	-49,728	EMERGENCY		91.00	0	34.06
34.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.07
34.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	34.08
34.10 MISC REVENUE	B	-40,090	NUTRITION COUNSELING		91.03	0	34.10
35.00 SISTERS MEALS	A	-42,768	CAFETERIA		11.00	0	35.00
35.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	35.10
36.00 EMS	B	-49,418	PARAMED ED PRGM-AMBULANCE		23.00	0	36.00
37.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	37.00
38.00 EMPLOYEE ASSISTANCE PROGRAM	B	-88,459	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	38.00
39.00 PSYCH EDUCATION	B	-46,581	ADULTS & PEDIATRICS		30.00	0	39.00
40.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	40.00
41.00 RENT	B	-296,699	C'VILLE OUT		91.01	0	41.00
42.00 MISC REVENUE		0			0.00	0	42.00
43.00 MISC REVENUE		0			0.00	0	43.00
44.00 LOBBYING EXPENSE		0			0.00	0	44.00
45.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	45.00
46.00 FAS 87 REV NEGATIVE EXP		0			0.00	0	46.00
47.00 ADD BACK DEPRECIATION ON IMPAIR	A	2,829,215	CAP REL COSTS-BLDG & FIXT		1.00	9	47.00
48.00 ADD BACK DEPRECIATION ON IMPAIR	A	636,049	CAP REL COSTS-MVBLE EQUIP		2.00	9	48.00
49.00 PENSION 3 EAR ADD BACK AND 10 YR AVE	A	0	EMPLOYEE BENEFITS DEPARTMENT		4.00	0	49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,018,326					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: 14-0217

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2018 10:52 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL-BLDG & FIXTURES	362,283	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	408,588	0	2.00
3.00	5.05	OTHER ADMIN AND GENERAL	A&G	14,176,989	18,128,839	3.00
3.01	0.00			0	0	3.01
3.02	5.04	CASHIERING/ACCOUNTS RECEIVAB	PATIENT ACCOUNTING	3,471,447	0	3.02
3.03	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	288,982	0	3.03
3.04	31.00	INTENSIVE CARE UNIT	ICU	412,652	0	3.04
3.05	60.00	LABORATORY	LAB	4,501,437	4,416,000	3.05
3.06	2.00	CAP REL COSTS-MVBLE EQUIP	MEDICAL EQUIPMENT	27,584	0	3.06
4.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,379,165	0	4.00
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			25,029,127	22,544,839	5.00

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

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

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

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

6.00	B	100.00	PRESENCE HEALTH	100.00	6.00
7.00	C	0.00	ALVERNO LABS	66.67	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0217

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2018 10:52 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	362,283	9		1.00
2.00	408,588	0		2.00
3.00	-3,951,850	0		3.00
3.01	0	0		3.01
3.02	3,471,447	0		3.02
3.03	288,982	9		3.03
3.04	412,652	0		3.04
3.05	85,437	0		3.05
3.06	27,584	9		3.06
4.00	1,379,165	0		4.00
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	2,484,288			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0217

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

Worksheet A-8-2

Date/Time Prepared:
5/29/2018 10:52 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER ADMIN AND GENERAL	677,556	632,821	44,735	211,500	358	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	31,950	0	31,950	211,500	213	2.00
3.00	30.00	ADULTS & PEDIATRICS	54,000	0	54,000	181,300	360	3.00
4.00	31.00	INTENSIVE CARE UNIT	516,996	516,996	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	99,200	0	99,200	181,300	1,240	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	1,988,500	1,988,500	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	130,544	55,526	75,018	271,900	519	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	144,967	37,835	107,132	271,900	857	9.00
10.00	59.00	CARDIAC CATHETERIZATION	23,160	9,385	13,775	211,500	92	10.00
11.00	60.00	LABORATORY	45,300	9,000	36,300	260,300	242	11.00
12.00	69.00	ELECTROCARDIOLOGY	9,000	0	9,000	211,500	60	12.00
13.00	91.00	EMERGENCY	2,176,494	2,094,794	81,700	211,500	605	13.00
200.00			5,897,667	5,344,857	552,810		4,546	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	5.05	OTHER ADMIN AND GENERAL	36,402	1,820	0	0	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	21,658	1,083	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	31,379	1,569	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	108,083	5,404	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	67,844	3,392	0	0	0	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	112,028	5,601	0	0	0	9.00
10.00	59.00	CARDIAC CATHETERIZATION	9,355	468	0	0	0	10.00
11.00	60.00	LABORATORY	30,285	1,514	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	6,101	305	0	0	0	12.00
13.00	91.00	EMERGENCY	61,518	3,076	0	0	0	13.00
200.00			484,653	24,232	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	5.05	OTHER ADMIN AND GENERAL	0	36,402	8,333	641,154	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	21,658	10,292	10,292	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	31,379	22,621	22,621	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	516,996	4.00
5.00	41.00	SUBPROVIDER - IRF	0	108,083	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	1,988,500	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	67,844	7,174	62,700	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	0	112,028	0	37,835	9.00
10.00	59.00	CARDIAC CATHETERIZATION	0	9,355	4,420	13,805	10.00
11.00	60.00	LABORATORY	0	30,285	6,015	15,015	11.00
12.00	69.00	ELECTROCARDIOLOGY	0	6,101	2,899	2,899	12.00
13.00	91.00	EMERGENCY	0	61,518	20,182	2,114,976	13.00
200.00			0	484,653	81,936	5,426,793	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,072,860	6,072,860			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,890,057		4,890,057		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	308,578	8,265	6,655	323,498	4.00
5.01 01160	COMMUNICATIONS	337,770	50,016	40,275	1,082	429,143 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	9,950	46,859	37,732	0	6,705 5.02
5.03 00570	ADMITTING	0	7,185	5,786	0	11,921 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	3,471,447	0	0	0	15,646 5.04
5.05 00590	OTHER ADMIN AND GENERAL	28,025,394	301,877	243,080	17,021	67,056 5.05
6.00 00600	MAINTENANCE & REPAIRS	1,969,217	631,433	508,450	34	745 6.00
7.00 00700	OPERATION OF PLANT	4,640,090	2,148,663	1,730,174	10,353	14,901 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	250,580	18,798	15,137	0	745 8.00
9.00 00900	HOUSEKEEPING	1,600,165	25,103	20,214	8,527	1,490 9.00
10.00 01000	DIETARY	1,476,397	180,170	145,078	7,547	9,686 10.00
11.00 01100	CAFETERIA	699,262	0	0	0	1,490 11.00
13.00 01300	NURSING ADMINISTRATION	3,410,720	15,006	12,083	19,880	15,646 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	734,210	70,021	56,383	3,193	3,725 14.00
15.00 01500	PHARMACY	2,294,773	23,861	19,213	14,983	5,215 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,970,655	62,400	50,247	3,088	14,901 16.00
23.00 02300	PARAMED ED PRGM-AMBULANCE	297,624	0	0	1,674	3,725 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	11,052,914	752,414	605,868	73,833	63,328 30.00
31.00 03100	INTENSIVE CARE UNIT	3,104,406	111,038	89,411	16,613	5,215 31.00
41.00 04100	SUBPROVIDER - IIRF	8,405,937	271,112	218,308	30,916	9,686 41.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,386,413	187,564	151,032	15,610	23,096 50.00
51.00 05100	RECOVERY ROOM	2,337,228	112,870	90,887	15,546	4,470 51.00
53.00 05300	ANESTHESIOLOGY	148,434	3,484	2,805	717	2,235 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,620,830	197,117	158,725	18,294	26,076 54.00
54.01 03650	VASCULAR LAB	435,238	14,480	11,659	2,992	745 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	1,839,549	280,638	225,978	7,712	23,096 55.00
57.00 05700	CT SCAN	495,885	14,616	11,769	3,274	0 57.00
58.00 05800	MRI	353,568	16,612	13,376	1,588	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	1,680,691	40,427	32,553	7,967	0 59.00
60.00 06000	LABORATORY	4,739,164	61,910	49,852	768	14,901 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	127	9,998	8,051	0	745 62.00
65.00 06500	RESPIRATORY THERAPY	1,184,081	14,353	11,557	7,582	5,215 65.00
66.00 06600	PHYSICAL THERAPY	2,308,608	0	0	18	6,705 66.00
67.00 06700	OCCUPATIONAL THERAPY	925	79,048	63,652	2	745 67.00
68.00 06800	SPEECH PATHOLOGY	913	0	0	0	745 68.00
69.00 06900	ELECTROCARDIOLOGY	672,979	71,046	57,209	4,365	5,215 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,916,511	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	7,002,487	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	9,312,758	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	531,402	5,507	4,434	0	0 74.00
76.00 03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0 76.00
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	394,404	23,652	19,045	2,424	12,666 76.02
76.03 03951	OCCUPATIONAL HEALTH	0	0	0	0	0 76.03
76.97 07697	CARDIAC REHABILITATION	310,501	7,013	5,647	1,543	0 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	871,676	0	0	1,106	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT PROCEDURES	0	0	0	0	0 90.01
91.00 09100	EMERGENCY	3,323,242	189,369	152,486	20,244	23,841 91.00
91.01 09101	CIVILLE OUT	17,380	0	0	199	745 91.01
91.02 09102	LAKE HILL OUT	0	0	0	0	0 91.02
91.03 09103	NUTRITION COUNSELING	357,458	0	0	2,070	0 91.03
91.04 09104	HUNTLEY OP	0	0	0	0	0 91.04
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 through 117)	141,265,458	6,053,925	4,874,811	322,765	403,067 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,727	11,053	0	1,490 190.00
194.00 07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0 194.00
194.01 07951	MOB	67,682	0	0	0	21,606 194.01
194.02 07952	COMMUNITY WELLNESS	105,199	0	0	733	0 194.02
194.03 07953	FUND DEVELOPMENT	0	5,208	4,193	0	2,980 194.03
194.04 07954	PHYSICIAN PRACTICE MANAGEMENT	96	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	141,438,435	6,072,860	4,890,057	323,498	429,143	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	101,246					5.02
5.03	00570	ADMINITTING	0	24,892				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	3,487,093			5.04
5.05	00590	OTHER ADMIN AND GENERAL	1,058	0	0	28,655,486	28,655,486	5.05
6.00	00600	MAINTENANCE & REPAIRS	32	0	0	3,109,911	790,154	6.00
7.00	00700	OPERATION OF PLANT	6,313	0	0	8,550,494	2,172,475	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	285,260	72,478	8.00
9.00	00900	HOUSEKEEPING	821	0	0	1,656,320	420,831	9.00
10.00	01000	DIETARY	1,327	0	0	1,820,205	462,470	10.00
11.00	01100	CAFETERIA	0	0	0	700,752	178,044	11.00
13.00	01300	NURSING ADMINISTRATION	737	0	0	3,474,072	882,678	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,668	0	0	876,200	222,621	14.00
15.00	01500	PHARMACY	932	0	0	2,358,977	599,359	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113	0	0	2,101,404	533,916	16.00
23.00	02300	PARAMED PRGM-AMBULANCE	1,181	0	0	304,204	77,291	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,678	2,971	412,385	12,973,391	3,296,271	30.00
31.00	03100	INTENSIVE CARE UNIT	2,351	626	86,940	3,416,600	868,076	31.00
41.00	04100	SUBPROVIDER - IIRF	5,258	1,167	161,975	9,104,359	2,313,199	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,898	4,482	654,223	4,456,318	1,132,243	50.00
51.00	05100	RECOVERY ROOM	1,840	1,134	157,423	2,721,398	691,442	51.00
53.00	05300	ANESTHESIOLOGY	329	557	77,253	235,814	59,915	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,097	901	125,088	3,148,128	799,864	54.00
54.01	03650	VASCULAR LAB	380	357	49,605	515,456	130,965	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	962	497	69,020	2,447,452	621,839	55.00
57.00	05700	CT SCAN	589	1,606	222,863	750,602	190,710	57.00
58.00	05800	MRI	126	480	66,576	452,326	114,925	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,170	1,709	237,251	2,006,768	509,872	59.00
60.00	06000	LABORATORY	1,557	1,770	245,685	5,115,607	1,299,753	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	53	7,312	26,286	6,679	62.00
65.00	06500	RESPIRATORY THERAPY	705	389	54,062	1,277,944	324,695	65.00
66.00	06600	PHYSICAL THERAPY	1,249	756	104,935	2,422,271	615,441	66.00
67.00	06700	OCCUPATIONAL THERAPY	20	346	48,033	192,771	48,978	67.00
68.00	06800	SPEECH PATHOLOGY	62	93	12,860	14,673	3,728	68.00
69.00	06900	ELECTROCARDIOLOGY	942	666	92,476	904,898	229,913	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	143	19,786	11,936,440	3,032,763	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,002,487	1,779,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,398	193,982	9,508,138	2,415,790	73.00
74.00	07400	RENAL DIALYSIS	0	114	15,851	557,308	141,599	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	293	40,611	493,095	125,284	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	160	54	7,440	332,358	84,444	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	6,137	261	36,200	915,380	232,576	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,731	2,034	282,367	3,998,314	1,015,876	91.00
91.01	09101	CVILLE OUT	1,407	25	3,524	23,280	5,915	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	363	10	1,367	361,268	91,790	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
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 through 117)	101,193	24,892	3,487,093	141,204,415	28,596,026	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	26,270	6,675	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	26	0	0	89,314	22,693	194.01
194.02	07952	COMMUNITY WELLNESS	27	0	0	105,959	26,922	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	12,381	3,146	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	96	24	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers				0		201.00
202.00		TOTAL (sum lines 118 through 201)	101,246	24,892	3,487,093	141,438,435	28,655,486	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		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
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600	3,900,065					6.00
7.00	00700	1,666,907	12,389,876				7.00
8.00	00800	14,583	80,911	453,232			8.00
9.00	00900	19,475	108,050	0	2,204,676		9.00
10.00	01000	139,774	775,485	0	140,128	3,338,062	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	11,641	64,588	0	11,671	0	13.00
14.00	01400	54,322	301,384	0	54,459	0	14.00
15.00	01500	18,511	102,700	0	18,558	0	15.00
16.00	01600	48,409	268,583	0	48,532	0	16.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	583,715	3,238,537	288,288	585,198	2,042,073	30.00
31.00	03100	86,142	477,927	12,947	86,360	31,015	31.00
41.00	04100	210,326	1,166,918	151,997	210,859	1,061,682	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	145,510	807,310	0	145,879	0	50.00
51.00	05100	87,564	485,815	0	87,786	10,969	51.00
53.00	05300	2,703	14,995	0	2,710	0	53.00
54.00	05400	152,921	848,430	0	153,309	0	54.00
54.01	03650	11,233	62,323	0	11,262	18,380	54.01
55.00	05500	217,716	1,207,920	0	218,268	21,547	55.00
57.00	05700	11,339	62,909	0	11,367	0	57.00
58.00	05800	12,887	71,500	0	12,920	0	58.00
59.00	05900	31,363	174,005	0	31,442	0	59.00
60.00	06000	48,029	266,474	0	48,151	0	60.00
62.00	06200	7,756	43,033	0	7,776	0	62.00
65.00	06500	11,135	61,776	0	11,163	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	61,325	340,239	0	61,480	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	55,117	305,797	0	55,257	0	69.00
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	4,272	23,703	0	4,283	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	18,349	101,802	0	18,395	78,483	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	5,441	30,185	0	5,454	0	76.97
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	146,911	815,081	0	147,283	73,913	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	0	0	0	0	0	91.03
91.04	09104	0	0	0	0	0	91.04
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		3,885,376	12,308,380	453,232	2,189,950	3,338,062	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	10,649	59,082	0	10,676	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	4,040	22,414	0	4,050	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		3,900,065	12,389,876	453,232	2,204,676	3,338,062	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
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	878,796					11.00
13.00	01300	52,281	4,496,931				13.00
14.00	01400	16,252	278	1,525,516			14.00
15.00	01500	36,350	0	0	3,134,455		15.00
16.00	01600	7,673	3,485	0	0	3,012,002	16.00
23.00	02300	10,418	286	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	252,068	1,915,340	0	0	356,231	30.00
31.00	03100	46,834	405,902	0	0	75,102	31.00
41.00	04100	107,930	909,147	0	0	139,920	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	46,894	208,026	0	0	564,876	50.00
51.00	05100	46,860	372,066	0	0	135,987	51.00
53.00	05300	2,028	84	0	0	66,734	53.00
54.00	05400	54,989	57,059	0	0	108,055	54.00
54.01	03650	7,654	0	0	0	42,850	54.01
55.00	05500	22,565	75,812	0	0	59,622	55.00
57.00	05700	10,597	0	0	0	192,517	57.00
58.00	05800	3,725	0	0	0	57,510	58.00
59.00	05900	18,413	72,824	0	0	204,945	59.00
60.00	06000	1,999	18,071	0	0	212,230	60.00
62.00	06200	0	0	0	0	6,316	62.00
65.00	06500	25,436	0	0	0	46,701	65.00
66.00	06600	38	0	0	0	90,646	66.00
67.00	06700	5	0	0	0	41,492	67.00
68.00	06800	0	0	0	0	11,109	68.00
69.00	06900	14,137	10,210	0	0	79,884	69.00
71.00	07100	0	0	960,877	0	17,092	71.00
72.00	07200	0	0	564,639	0	0	72.00
73.00	07300	5,343	40,528	0	3,134,455	167,568	73.00
74.00	07400	0	0	0	0	13,693	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	7,904	13,863	0	0	35,081	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	4,808	16,632	0	0	6,427	76.97
76.98	07698	2,918	0	0	0	31,271	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	62,581	377,091	0	0	243,918	91.00
91.01	09101	1,888	0	0	0	3,044	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	6,573	0	0	0	1,181	91.03
91.04	09104	0	0	0	0	0	91.04
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		877,161	4,496,704	1,525,516	3,134,455	3,012,002	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	1,635	227	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		878,796	4,496,931	1,525,516	3,134,455	3,012,002	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prepared: 5/29/2018 10:52 am
Cost Center Description			PARAMED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01160	COMMUNICATIONS				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMINISTRATIVE				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER ADMIN AND GENERAL				5.05
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
23.00	02300	PARAMED PRGM-AMBULANCE	392,199			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,240	25,540,352	0	30.00
31.00	03100	INTENSIVE CARE UNIT	44,148	5,551,053	0	31.00
41.00	04100	SUBPROVIDER - I RF	0	15,376,337	0	41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,481	7,525,537	0	50.00
51.00	05100	RECOVERY ROOM	0	4,639,887	0	51.00
53.00	05300	ANESTHESIOLOGY	26,694	411,677	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,322,755	0	54.00
54.01	03650	VASCULAR LAB	0	800,123	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,892,741	0	55.00
57.00	05700	CT SCAN	0	1,230,041	0	57.00
58.00	05800	MRI	0	725,793	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,481	3,068,113	0	59.00
60.00	06000	LABORATORY	0	7,010,314	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	97,846	0	62.00
65.00	06500	RESPIRATORY THERAPY	9,240	1,768,090	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,128,396	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	746,290	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	29,510	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,655,213	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,947,172	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,346,290	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,271,822	0	73.00
74.00	07400	RENAL DIALYSIS	0	744,858	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	892,256	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	485,749	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	1,182,145	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	90.01
91.00	09100	EMERGENCY	257,701	7,138,669	0	91.00
91.01	09101	CVILLE OUT	0	34,127	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	460,812	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	383,985	141,023,968	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	113,352	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	194.00
194.01	07951	MOB	0	112,007	0	194.01
194.02	07952	COMMUNITY WELLNESS	8,214	142,957	0	194.02
194.03	07953	FUND DEVELOPMENT	0	46,031	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	120	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	392,199	141,438,435	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 10:52 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
		0	1.00				2.00	2A
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	2,985	8,265	6,655	17,905	17,905	4.00
5.01	01160	COMMUNICATIONS	16,748	50,016	40,275	107,039	60	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	46,859	37,732	84,591	0	5.02
5.03	00570	ADMITTING	0	7,185	5,786	12,971	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	71,486	301,877	243,080	616,443	941	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	631,433	508,450	1,139,883	2	6.00
7.00	00700	OPERATION OF PLANT	3,369	2,148,663	1,730,174	3,882,206	573	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,798	15,137	33,935	0	8.00
9.00	00900	HOUSEKEEPING	1,706	25,103	20,214	47,023	472	9.00
10.00	01000	DIETARY	15,834	180,170	145,078	341,082	417	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,097	15,006	12,083	29,186	1,100	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	155,959	70,021	56,383	282,363	177	14.00
15.00	01500	PHARMACY	156,199	23,861	19,213	199,273	829	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	687	62,400	50,247	113,334	171	16.00
23.00	02300	PARAMED PRGM-AMBULANCE	1,068	0	0	1,068	93	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,137	752,414	605,868	1,366,419	4,095	30.00
31.00	03100	INTENSIVE CARE UNIT	5,432	111,038	89,411	205,881	919	31.00
41.00	04100	SUBPROVIDER - IRF	6,482	271,112	218,308	495,902	1,710	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	72,878	187,564	151,032	411,474	863	50.00
51.00	05100	RECOVERY ROOM	4,524	112,870	90,887	208,281	860	51.00
53.00	05300	ANESTHESIOLOGY	4	3,484	2,805	6,293	40	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,003	197,117	158,725	360,845	1,012	54.00
54.01	03650	VASCULAR LAB	73	14,480	11,659	26,212	165	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	5,425	280,638	225,978	512,041	427	55.00
57.00	05700	CT SCAN	165	14,616	11,769	26,550	181	57.00
58.00	05800	MRI	1,672	16,612	13,376	31,660	88	58.00
59.00	05900	CARDIAC CATHETERIZATION	73,776	40,427	32,553	146,756	441	59.00
60.00	06000	LABORATORY	3,954	61,910	49,852	115,716	42	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	127	9,998	8,051	18,176	0	62.00
65.00	06500	RESPIRATORY THERAPY	35,026	14,353	11,557	60,936	419	65.00
66.00	06600	PHYSICAL THERAPY	83,651	0	0	83,651	1	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	79,048	63,652	142,700	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,288	71,046	57,209	132,543	241	69.00
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	5,507	4,434	9,941	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,688	23,652	19,045	44,385	134	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	70,791	7,013	5,647	83,451	85	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	82,519	0	0	82,519	61	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	23,857	189,369	152,486	365,712	1,120	91.00
91.01	09101	CIVILLE OUT	78,319	0	0	78,319	11	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	28	0	0	28	114	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
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 through 117)	995,957	6,053,925	4,874,811	11,924,693	17,864	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,727	11,053	24,780	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	6,580	0	0	6,580	0	194.01
194.02	07952	COMMUNITY WELLNESS	2,446	0	0	2,446	41	194.02
194.03	07953	FUND DEVELOPMENT	0	5,208	4,193	9,401	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 10:52 am	
		CAPITAL RELATED COSTS				Subtotal	EMPLOYEE BENEFITS DEPARTMENT
Cost Center Description		Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118 through 201)	1,004,983	6,072,860	4,890,057	11,967,900	17,905	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 10:52 am	
Cost Center Description		COMMUNICATIONS	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160	107,099					5.01
5.02	00560	1,673	86,264				5.02
5.03	00570	2,975	0	15,946			5.03
5.04	00580	3,905	0	0	3,905		5.04
5.05	00590	16,729	902	0	0	635,015	5.05
6.00	00600	186	27	0	0	17,509	6.00
7.00	00700	3,719	5,379	0	0	48,139	7.00
8.00	00800	186	0	0	0	1,606	8.00
9.00	00900	372	699	0	0	9,325	9.00
10.00	01000	2,417	1,131	0	0	10,248	10.00
11.00	01100	372	0	0	0	3,945	11.00
13.00	01300	3,905	628	0	0	19,559	13.00
14.00	01400	930	7,386	0	0	4,933	14.00
15.00	01500	1,302	794	0	0	13,281	15.00
16.00	01600	3,719	97	0	0	11,831	16.00
23.00	02300	930	1,007	0	0	1,713	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,805	8,245	1,882	495	73,084	30.00
31.00	03100	1,302	2,003	397	104	19,235	31.00
41.00	04100	2,417	4,480	739	194	51,258	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	5,764	28,881	3,020	503	25,089	50.00
51.00	05100	1,116	1,568	718	189	15,321	51.00
53.00	05300	558	281	353	93	1,328	53.00
54.00	05400	6,508	935	571	150	17,724	54.00
54.01	03650	186	324	226	60	2,902	54.01
55.00	05500	5,764	820	315	83	13,779	55.00
57.00	05700	0	502	1,017	268	4,226	57.00
58.00	05800	0	107	304	80	2,547	58.00
59.00	05900	0	5,257	1,083	285	11,298	59.00
60.00	06000	3,719	1,326	1,121	295	28,801	60.00
62.00	06200	186	0	33	9	148	62.00
65.00	06500	1,302	600	247	65	7,195	65.00
66.00	06600	1,673	1,064	479	126	13,637	66.00
67.00	06700	186	17	219	58	1,085	67.00
68.00	06800	186	52	59	15	83	68.00
69.00	06900	1,302	803	422	111	5,095	69.00
71.00	07100	0	0	90	24	67,202	71.00
72.00	07200	0	0	0	0	39,424	72.00
73.00	07300	0	0	885	233	53,531	73.00
74.00	07400	0	0	72	19	3,138	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	3,161	0	185	49	2,776	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	0	136	34	9	1,871	76.97
76.98	07698	0	5,229	165	43	5,154	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	5,950	4,031	1,288	339	22,511	91.00
91.01	09101	186	1,199	16	4	131	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	0	309	6	2	2,034	91.03
91.04	09104	0	0	0	0	0	91.04
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
		100,591	86,219	15,946	3,905	633,696	
NONREIMBURSABLE COST CENTERS							
190.00	19000	372	0	0	0	148	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	5,392	22	0	0	503	194.01
194.02	07952	0	23	0	0	597	194.02
194.03	07953	744	0	0	0	70	194.03
194.04	07954	0	0	0	0	1	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		107,099	86,264	15,946	3,905	635,015	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 10:52 am	
Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMIN AND GENERAL						5.05
6.00	00600	MAINTENANCE & REPAIRS	1,157,607					6.00
7.00	00700	OPERATION OF PLANT	494,767	4,434,783				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,329	28,961	69,017			8.00
9.00	00900	HOUSEKEEPING	5,781	38,675	0	102,347		9.00
10.00	01000	DIETARY	41,487	277,574	0	6,505	680,861	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,455	23,118	0	542	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,124	107,876	0	2,528	0	14.00
15.00	01500	PHARMACY	5,494	36,760	0	861	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,369	96,135	0	2,253	0	16.00
23.00	02300	PARAMED PRGM-AMBULANCE	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	173,257	1,159,189	43,899	27,166	416,520	30.00
31.00	03100	INTENSIVE CARE UNIT	25,568	171,067	1,972	4,009	6,326	31.00
41.00	04100	SUBPROVIDER - IIRF	62,428	417,682	23,146	9,789	216,550	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	43,190	288,965	0	6,772	0	50.00
51.00	05100	RECOVERY ROOM	25,990	173,891	0	4,075	2,237	51.00
53.00	05300	ANESTHESIOLOGY	802	5,367	0	126	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,390	303,684	0	7,117	0	54.00
54.01	03650	VASCULAR LAB	3,334	22,308	0	523	3,749	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	64,622	432,358	0	10,133	4,395	55.00
57.00	05700	CT SCAN	3,366	22,517	0	528	0	57.00
58.00	05800	MRI	3,825	25,592	0	600	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,309	62,283	0	1,460	0	59.00
60.00	06000	LABORATORY	14,256	95,381	0	2,235	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,302	15,403	0	361	0	62.00
65.00	06500	RESPIRATORY THERAPY	3,305	22,112	0	518	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,202	121,784	0	2,854	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	16,360	109,456	0	2,565	0	69.00
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	1,268	8,484	0	199	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	5,446	36,439	0	854	16,008	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,615	10,804	0	253	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	43,606	291,747	0	6,837	15,076	91.00
91.01	09101	CIVILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
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 through 117)	1,153,247	4,405,612	69,017	101,663	680,861	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,161	21,148	0	496	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	0	194.02
194.03	07953	FUND DEVELOPMENT	1,199	8,023	0	188	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,157,607	4,434,783	69,017	102,347	680,861	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/29/2018 10:52 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
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	4,317					11.00
13.00	01300	257	81,750				13.00
14.00	01400	80	5	422,402			14.00
15.00	01500	179	0	0	258,773		15.00
16.00	01600	38	63	0	0	242,010	16.00
23.00	02300	51	5	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,240	34,819	0	0	28,621	30.00
31.00	03100	230	7,379	0	0	6,034	31.00
41.00	04100	530	16,527	0	0	11,242	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	230	3,782	0	0	45,395	50.00
51.00	05100	230	6,764	0	0	10,926	51.00
53.00	05300	10	2	0	0	5,362	53.00
54.00	05400	270	1,037	0	0	8,682	54.00
54.01	03650	38	0	0	0	3,443	54.01
55.00	05500	111	1,378	0	0	4,790	55.00
57.00	05700	52	0	0	0	15,468	57.00
58.00	05800	18	0	0	0	4,621	58.00
59.00	05900	90	1,324	0	0	16,466	59.00
60.00	06000	10	329	0	0	17,052	60.00
62.00	06200	0	0	0	0	507	62.00
65.00	06500	125	0	0	0	3,752	65.00
66.00	06600	0	0	0	0	7,283	66.00
67.00	06700	0	0	0	0	3,334	67.00
68.00	06800	0	0	0	0	893	68.00
69.00	06900	69	186	0	0	6,418	69.00
71.00	07100	0	0	266,057	0	1,373	71.00
72.00	07200	0	0	156,345	0	0	72.00
73.00	07300	26	737	0	258,773	13,463	73.00
74.00	07400	0	0	0	0	1,100	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	39	252	0	0	2,819	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	24	302	0	0	516	76.97
76.98	07698	14	0	0	0	2,512	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	307	6,855	0	0	19,598	91.00
91.01	09101	9	0	0	0	245	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	32	0	0	0	95	91.03
91.04	09104	0	0	0	0	0	91.04
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		4,309	81,746	422,402	258,773	242,010	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	8	4	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		4,317	81,750	422,402	258,773	242,010	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/29/2018 10:52 am
Cost Center Description	PARAMED ED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	23.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 01160	COMMUNICATIONS					5.01
5.02 00560	PURCHASING RECEIVING AND STORES					5.02
5.03 00570	ADMINISTRATIVE					5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05 00590	OTHER ADMIN AND GENERAL					5.05
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
23.00 02300	PARAMED ED PRGM-AMBULANCE	4,867				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS		3,354,736	0	3,354,736	30.00
31.00 03100	INTENSIVE CARE UNIT		452,426	0	452,426	31.00
41.00 04100	SUBPROVIDER - I RF		1,314,594	0	1,314,594	41.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM		863,928	0	863,928	50.00
51.00 05100	RECOVERY ROOM		452,166	0	452,166	51.00
53.00 05300	ANESTHESIOLOGY		20,615	0	20,615	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC		753,925	0	753,925	54.00
54.01 03650	VASCULAR LAB		63,470	0	63,470	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC		1,051,016	0	1,051,016	55.00
57.00 05700	CT SCAN		74,675	0	74,675	57.00
58.00 05800	MRI		69,442	0	69,442	58.00
59.00 05900	CARDIAC CATHETERIZATION		256,052	0	256,052	59.00
60.00 06000	LABORATORY		280,283	0	280,283	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL		37,125	0	37,125	62.00
65.00 06500	RESPIRATORY THERAPY		100,576	0	100,576	65.00
66.00 06600	PHYSICAL THERAPY		107,914	0	107,914	66.00
67.00 06700	OCCUPATIONAL THERAPY		290,439	0	290,439	67.00
68.00 06800	SPEECH PATHOLOGY		1,288	0	1,288	68.00
69.00 06900	ELECTROCARDIOLOGY		275,571	0	275,571	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT		334,746	0	334,746	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		195,769	0	195,769	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		327,648	0	327,648	73.00
74.00 07400	RENAL DIALYSIS		24,221	0	24,221	74.00
76.00 03950	OTHER ANCILLARY SERVICES COST CENTER		0	0	0	76.00
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		112,547	0	112,547	76.02
76.03 03951	OCCUPATIONAL HEALTH		0	0	0	76.03
76.97 07697	CARDIAC REHABILITATION		99,100	0	99,100	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY		95,697	0	95,697	76.98
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT PROCEDURES		0	0	0	90.01
91.00 09100	EMERGENCY		784,977	0	784,977	91.00
91.01 09101	CVILLE OUT		80,120	0	80,120	91.01
91.02 09102	LAKE HILL OUT		0	0	0	91.02
91.03 09103	NUTRITION COUNSELING		2,620	0	2,620	91.03
91.04 09104	HUNTLEY OP		0	0	0	91.04
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE		0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	11,877,686	0	11,877,686	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		50,105	0	50,105	190.00
194.00 07950	MISC NONREIMBURSABLE COST CENTER		0	0	0	194.00
194.01 07951	MOB		12,497	0	12,497	194.01
194.02 07952	COMMUNITY WELLNESS		3,119	0	3,119	194.02
194.03 07953	FUND DEVELOPMENT		19,625	0	19,625	194.03
194.04 07954	PHYSICIAN PRACTICE MANAGEMENT		1	0	1	194.04
200.00	Cross Foot Adjustments	4,867	4,867	0	4,867	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4,867	11,967,900	0	11,967,900	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHONES)	PURCHASING RECEIVING AND STORES (PURCH REQUIS \$)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	669,374				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		669,374			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	911	911	39,325,585		4.00
5.01 01160	COMMUNICATIONS	5,513	5,513	131,479	576	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	5,165	5,165	0	9	1,239,324 5.02
5.03 00570	ADMITTING	792	792	0	16	0 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	21	0 5.04
5.05 00590	OTHER ADMIN AND GENERAL	33,274	33,274	2,069,225	90	12,954 5.05
6.00 00600	MAINTENANCE & REPAIRS	69,599	69,599	4,118	1	393 6.00
7.00 00700	OPERATION OF PLANT	236,834	236,834	1,258,535	20	77,281 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,072	2,072	0	1	0 8.00
9.00 00900	HOUSEKEEPING	2,767	2,767	1,036,633	2	10,045 9.00
10.00 01000	DIETARY	19,859	19,859	917,450	13	16,243 10.00
11.00 01100	CAFETERIA	0	0	0	2	0 11.00
13.00 01300	NURSING ADMINISTRATION	1,654	1,654	2,416,688	21	9,020 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	7,718	7,718	388,187	5	106,108 14.00
15.00 01500	PHARMACY	2,630	2,630	1,821,434	7	11,411 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	6,878	6,878	375,431	20	1,387 16.00
23.00 02300	PARAMED ED PRGM-AMBULANCE	0	0	203,533	5	14,460 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	82,934	82,934	8,974,761	85	118,459 30.00
31.00 03100	INTENSIVE CARE UNIT	12,239	12,239	2,019,608	7	28,779 31.00
41.00 04100	SUBPROVIDER - I/R	29,883	29,883	3,758,298	13	64,360 41.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	20,674	20,674	1,897,586	31	414,922 50.00
51.00 05100	RECOVERY ROOM	12,441	12,441	1,889,915	6	22,522 51.00
53.00 05300	ANESTHESIOLOGY	384	384	87,219	3	4,031 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,727	21,727	2,223,945	35	13,432 54.00
54.01 03650	VASCULAR LAB	1,596	1,596	363,710	1	4,653 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	30,933	30,933	937,487	31	11,780 55.00
57.00 05700	CT SCAN	1,611	1,611	398,016	0	7,208 57.00
58.00 05800	MRI	1,831	1,831	193,017	0	1,539 58.00
59.00 05900	CARDIAC CATHETERIZATION	4,456	4,456	968,512	0	75,519 59.00
60.00 06000	LABORATORY	6,824	6,824	93,346	20	19,057 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,102	1,102	0	1	0 62.00
65.00 06500	RESPIRATORY THERAPY	1,582	1,582	921,761	7	8,627 65.00
66.00 06600	PHYSICAL THERAPY	0	0	2,191	9	15,290 66.00
67.00 06700	OCCUPATIONAL THERAPY	8,713	8,713	195	1	245 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	1	754 68.00
69.00 06900	ELECTROCARDIOLOGY	7,831	7,831	530,691	7	11,530 69.00
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	607	607	0	0	0 74.00
76.00 03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0 76.00
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,607	2,607	294,648	17	0 76.02
76.03 03951	OCCUPATIONAL HEALTH	0	0	0	0	0 76.03
76.97 07697	CARDIAC REHABILITATION	773	773	187,597	0	1,960 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	134,479	0	75,125 76.98
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT PROCEDURES	0	0	0	0	0 90.01
91.00 09100	EMERGENCY	20,873	20,873	2,460,966	32	57,912 91.00
91.01 09101	CIVILLE OUT	0	0	24,214	1	17,228 91.01
91.02 09102	LAKE HILL OUT	0	0	0	0	0 91.02
91.03 09103	NUTRITION COUNSELING	0	0	251,597	0	4,442 91.03
91.04 09104	HUNTLEY OP	0	0	0	0	0 91.04
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 through 117)	667,287	667,287	39,236,472	541	1,238,676 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,513	1,513	0	2	0 190.00
194.00 07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0 194.00
194.01 07951	MOB	0	0	0	29	315 194.01
194.02 07952	COMMUNITY WELLNESS	0	0	89,113	0	333 194.02
194.03 07953	FUND DEVELOPMENT	574	574	0	4	0 194.03
194.04 07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHONES)	PURCHASING RECEIVING AND STORES (PURCH REQUIS \$)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					4.00
201.00	Negative Cost Centers					201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	6,072,860	4,890,057	323,498	429,143	101,246	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.072447	7.305418	0.008226	745.039931	0.081695	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			17,905	107,099	86,264	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000455	185.935764	0.069606	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description			ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	6.00	
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
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMINISTRATIVE	837,379,445					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	837,379,445				5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	-28,655,486	112,782,949		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	3,109,911	554,120	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	8,550,494	236,834	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	285,260	2,072	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,656,320	2,767	9.00
10.00	01000	DIETARY	0	0	0	1,820,205	19,859	10.00
11.00	01100	CAFETERIA	0	0	0	700,752	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,474,072	1,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	876,200	7,718	14.00
15.00	01500	PHARMACY	0	0	0	2,358,977	2,630	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	2,101,404	6,878	16.00
23.00	02300	PARAMEDICAL PRGM-AMBULANCE	0	0	0	304,204	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	99,035,667	99,035,667	0	12,973,391	82,934	30.00
31.00	03100	INTENSIVE CARE UNIT	20,879,012	20,879,012	0	3,416,600	12,239	31.00
41.00	04100	SUBPROVIDER - IRF	38,898,992	38,898,992	0	9,104,359	29,883	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	157,055,325	157,055,325	0	4,456,318	20,674	50.00
51.00	05100	RECOVERY ROOM	37,805,693	37,805,693	0	2,721,398	12,441	51.00
53.00	05300	ANESTHESIOLOGY	18,552,706	18,552,706	0	235,814	384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,040,322	30,040,322	0	3,148,128	21,727	54.00
54.01	03650	VASCULAR LAB	11,912,736	11,912,736	0	515,456	1,596	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	16,575,450	16,575,450	0	2,447,452	30,933	55.00
57.00	05700	CT SCAN	53,521,493	53,521,493	0	750,602	1,611	57.00
58.00	05800	MRI	15,988,417	15,988,417	0	452,326	1,831	58.00
59.00	05900	CARDIAC CATHETERIZATION	56,976,779	56,976,779	0	2,006,768	4,456	59.00
60.00	06000	LABORATORY	59,002,053	59,002,053	0	5,115,607	6,824	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,756,010	1,756,010	0	26,286	1,102	62.00
65.00	06500	RESPIRATORY THERAPY	12,983,306	12,983,306	0	1,277,944	1,582	65.00
66.00	06600	PHYSICAL THERAPY	25,200,519	25,200,519	0	2,422,271	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	11,535,195	11,535,195	0	192,771	8,713	67.00
68.00	06800	SPEECH PATHOLOGY	3,088,278	3,088,278	0	14,673	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,208,550	22,208,550	0	904,898	7,831	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,751,628	4,751,628	0	11,936,440	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,002,487	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,585,398	46,585,398	0	9,508,138	0	73.00
74.00	07400	RENAL DIALYSIS	3,806,724	3,806,724	0	557,308	607	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	9,752,823	9,752,823	0	493,095	2,607	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,786,721	1,786,721	0	332,358	773	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	8,693,592	8,693,592	0	915,380	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	67,811,542	67,811,542	0	3,998,314	20,873	91.00
91.01	09101	CIVILLE OUT	846,245	846,245	0	23,280	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	328,269	328,269	0	361,268	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
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	11800	SUBTOTALS (SUM OF LINES 1 through 117)	837,379,445	837,379,445	-28,655,486	112,548,929	552,033	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	26,270	1,513	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	89,314	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	105,959	0	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	12,381	574	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	96	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		ADM ITTING (GROSS CHAR GES)	CASH I ERING/ACC OUNTS RECEIVABLE (GROSS CHAR GES)	Reconci li ati on	OTHER ADMIN AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	24,892	3,487,093		28,655,486	3,900,065	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000030	0.004164		0.254076	7.038304	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	15,946	3,905		635,015	1,157,607	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000019	0.000005		0.005630	2.089091	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)		
		7.00	8.00	9.00	10.00	11.00		
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	
5.01	01160	COMMUNICATIONS					5.01	
5.02	00560	PURCHASING RECEIVING AND STORES					5.02	
5.03	00570	ADMITTING					5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04	
5.05	00590	OTHER ADMIN AND GENERAL					5.05	
6.00	00600	MAINTENANCE & REPAIRS					6.00	
7.00	00700	OPERATION OF PLANT	317,286				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	2,072	38,788			8.00	
9.00	00900	HOUSEKEEPING	2,767	0	312,447		9.00	
10.00	01000	DIETARY	19,859	0	19,859	102,247	10.00	
11.00	01100	CAFETERIA	0	0	0	977,397	11.00	
13.00	01300	NURSING ADMINISTRATION	1,654	0	1,654	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	7,718	0	7,718	0	14.00	
15.00	01500	PHARMACY	2,630	0	2,630	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	6,878	0	6,878	0	16.00	
23.00	02300	PARAMED PRGM-AMBULANCE	0	0	0	11,587	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	82,934	24,672	82,934	62,550	280,347	30.00
31.00	03100	INTENSIVE CARE UNIT	12,239	1,108	12,239	950	52,089	31.00
41.00	04100	SUBPROVIDER - IIRF	29,883	13,008	29,883	32,520	120,040	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	20,674	0	20,674	0	52,156	50.00
51.00	05100	RECOVERY ROOM	12,441	0	12,441	336	52,118	51.00
53.00	05300	ANESTHESIOLOGY	384	0	384	0	2,255	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,727	0	21,727	0	61,159	54.00
54.01	03650	VASCULAR LAB	1,596	0	1,596	563	8,513	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	30,933	0	30,933	660	25,097	55.00
57.00	05700	CT SCAN	1,611	0	1,611	0	11,786	57.00
58.00	05800	MRI	1,831	0	1,831	0	4,143	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,456	0	4,456	0	20,479	59.00
60.00	06000	LABORATORY	6,824	0	6,824	0	2,223	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,102	0	1,102	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,582	0	1,582	0	28,290	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	42	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,713	0	8,713	0	6	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7,831	0	7,831	0	15,723	69.00
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	5,942	73.00
74.00	07400	RENAL DIALYSIS	607	0	607	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,607	0	2,607	2,404	8,791	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	773	0	773	0	5,348	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	3,245	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	20,873	0	20,873	2,264	69,603	91.00
91.01	09101	CIVILLE OUT	0	0	0	0	2,100	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	7,311	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
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 through 117)	315,199	38,788	310,360	102,247	975,578	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,513	0	1,513	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	0	0	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	1,819	194.02
194.03	07953	FUND DEVELOPMENT	574	0	574	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
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)	12,389,876	453,232	2,204,676	3,338,062	878,796	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	39.049552	11.684851	7.056160	32.647041	0.899119	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	4,434,783	69,017	102,347	680,861	4,317	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	13.977241	1.779339	0.327566	6.658983	0.004417	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	PARAMED PRGM-AMBULANCE (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
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						11.00
13.00	01300	534,267					13.00
14.00	01400	33	18,918,998				14.00
15.00	01500	0	0	9,065,149			15.00
16.00	01600	414	0	0	837,379,445		16.00
23.00	02300	34	0	0	0	1,528	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	227,556	0	0	99,035,667	36	30.00
31.00	03100	48,224	0	0	20,879,012	172	31.00
41.00	04100	108,013	0	0	38,898,992	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	24,715	0	0	157,055,325	72	50.00
51.00	05100	44,204	0	0	37,805,693	0	51.00
53.00	05300	10	0	0	18,552,706	104	53.00
54.00	05400	6,779	0	0	30,040,322	0	54.00
54.01	03650	0	0	0	11,912,736	0	54.01
55.00	05500	9,007	0	0	16,575,450	0	55.00
57.00	05700	0	0	0	53,521,493	0	57.00
58.00	05800	0	0	0	15,988,417	0	58.00
59.00	05900	8,652	0	0	56,976,779	72	59.00
60.00	06000	2,147	0	0	59,002,053	0	60.00
62.00	06200	0	0	0	1,756,010	0	62.00
65.00	06500	0	0	0	12,983,306	36	65.00
66.00	06600	0	0	0	25,200,519	0	66.00
67.00	06700	0	0	0	11,535,195	0	67.00
68.00	06800	0	0	0	3,088,278	0	68.00
69.00	06900	1,213	0	0	22,208,550	0	69.00
71.00	07100	0	11,916,511	0	4,751,628	0	71.00
72.00	07200	0	7,002,487	0	0	0	72.00
73.00	07300	4,815	0	9,065,149	46,585,398	0	73.00
74.00	07400	0	0	0	3,806,724	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	1,647	0	0	9,752,823	0	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	1,976	0	0	1,786,721	0	76.97
76.98	07698	0	0	0	8,693,592	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	44,801	0	0	67,811,542	1,004	91.00
91.01	09101	0	0	0	846,245	0	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	0	0	0	328,269	0	91.03
91.04	09104	0	0	0	0	0	91.04
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		534,240	18,918,998	9,065,149	837,379,445	1,496	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	27	0	0	0	32	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	PARAMED PRGM-AMBULANCE (ASSIGNED TIME)	
		(DIRECT NRSING HRS)					
202.00	Cost to be allocated (per Wkst. B, Part I)	4,496,931	1,525,516	3,134,455	3,012,002	392,199	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.417011	0.080634	0.345770	0.003597	256.674738	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	81,750	422,402	258,773	242,010	4,867	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.153013	0.022327	0.028546	0.000289	3.185209	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0217

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 10:52 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	25,540,352		25,540,352	22,621	25,562,973	30.00
31.00	03100 INTENSIVE CARE UNIT	5,551,053		5,551,053	0	5,551,053	31.00
41.00	04100 SUBPROVIDER - I RF	15,376,337		15,376,337	0	15,376,337	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	7,525,537		7,525,537	0	7,525,537	50.00
51.00	05100 RECOVERY ROOM	4,639,887		4,639,887	0	4,639,887	51.00
53.00	05300 ANESTHESIOLOGY	411,677		411,677	0	411,677	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,322,755		5,322,755	7,174	5,329,929	54.00
54.01	03650 VASCULAR LAB	800,123		800,123	0	800,123	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	4,892,741		4,892,741	0	4,892,741	55.00
57.00	05700 CT SCAN	1,230,041		1,230,041	0	1,230,041	57.00
58.00	05800 MRI	725,793		725,793	0	725,793	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,068,113		3,068,113	4,420	3,072,533	59.00
60.00	06000 LABORATORY	7,010,314		7,010,314	6,015	7,016,329	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	97,846		97,846	0	97,846	62.00
65.00	06500 RESPIRATORY THERAPY	1,768,090	0	1,768,090	0	1,768,090	65.00
66.00	06600 PHYSICAL THERAPY	3,128,396	0	3,128,396	0	3,128,396	66.00
67.00	06700 OCCUPATIONAL THERAPY	746,290	0	746,290	0	746,290	67.00
68.00	06800 SPEECH PATHOLOGY	29,510	0	29,510	0	29,510	68.00
69.00	06900 ELECTROCARDIOLOGY	1,655,213		1,655,213	2,899	1,658,112	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,947,172		15,947,172	0	15,947,172	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9,346,290		9,346,290	0	9,346,290	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,271,822		15,271,822	0	15,271,822	73.00
74.00	07400 RENAL DIALYSIS	744,858		744,858	0	744,858	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0		0	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	892,256		892,256	0	892,256	76.02
76.03	03951 OCCUPATIONAL HEALTH	0		0	0	0	76.03
76.97	07697 CARDIAC REHABILITATION	485,749		485,749	0	485,749	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,182,145		1,182,145	0	1,182,145	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT PROCEDURES	0		0	0	0	90.01
91.00	09100 EMERGENCY	7,138,669		7,138,669	20,182	7,158,851	91.00
91.01	09101 CIVILLE OUT	34,127		34,127	0	34,127	91.01
91.02	09102 LAKE HILL OUT	0		0	0	0	91.02
91.03	09103 NUTRITION COUNSELING	460,812		460,812	0	460,812	91.03
91.04	09104 HUNTLEY OP	0		0	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,047,984		3,047,984	0	3,047,984	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	144,071,952	0	144,071,952	63,311	144,135,263	200.00
201.00	Less Observation Beds	3,047,984		3,047,984		3,047,984	201.00
202.00	Total (see instructions)	141,023,968	0	141,023,968	63,311	141,087,279	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/29/2018 10:52 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	81,955,593		81,955,593				30.00
31.00	03100	INTENSIVE CARE UNIT	20,813,753		20,813,753				31.00
41.00	04100	SUBPROVIDER - IRF	38,898,992		38,898,992				41.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	60,617,256	41,648,752	102,266,008	0.073588	0.000000		50.00
51.00	05100	RECOVERY ROOM	19,032,822	18,772,871	37,805,693	0.122730	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	10,205,920	8,346,786	18,552,706	0.022190	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,281,726	21,518,387	29,800,113	0.178615	0.000000		54.00
54.01	03650	VASCULAR LAB	2,746,853	8,944,190	11,691,043	0.068439	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	546,938	13,215,802	13,762,740	0.355506	0.000000		55.00
57.00	05700	CT SCAN	13,249,664	39,887,463	53,137,127	0.023148	0.000000		57.00
58.00	05800	MRI	3,755,964	12,230,792	15,986,756	0.045400	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	16,748,910	20,951,832	37,700,742	0.081381	0.000000		59.00
60.00	06000	LABORATORY	27,878,342	31,123,712	59,002,054	0.118815	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,150,575	605,041	1,755,616	0.055733	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	11,376,795	1,404,665	12,781,460	0.138332	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	15,876,852	9,323,667	25,200,519	0.124140	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,439,202	95,993	11,535,195	0.064697	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	3,025,119	63,159	3,088,278	0.009555	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	7,170,660	14,996,722	22,167,382	0.074669	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,469,729	12,259,698	22,729,427	0.701609	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,581,661	9,260,203	56,841,864	0.164426	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,627,843	34,659,000	61,286,843	0.249186	0.000000		73.00
74.00	07400	RENAL DIALYSIS	3,589,259	217,465	3,806,724	0.195669	0.000000		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0.000000	0.000000		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,656,021	1,096,802	9,752,823	0.091487	0.000000		76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	553	1,786,168	1,786,721	0.271866	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	61,814	8,583,461	8,645,275	0.136739	0.000000		76.98
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	0.000000		90.01
91.00	09100	EMERGENCY	15,815,651	44,831,366	60,647,017	0.117708	0.000000		91.00
91.01	09101	CIVILLE OUT	0	846,245	846,245	0.040328	0.000000		91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	0.000000		91.02
91.03	09103	NUTRITION COUNSELING	504	327,765	328,269	1.403763	0.000000		91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	0.000000		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,546,879	8,259,591	12,806,470	0.238003	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	472,121,850	365,257,598	837,379,448				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	472,121,850	365,257,598	837,379,448				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 10:52 am
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.073588		50.00
51.00	05100	RECOVERY ROOM	0.122730		51.00
53.00	05300	ANESTHESIOLOGY	0.022190		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178856		54.00
54.01	03650	VASCULAR LAB	0.068439		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.355506		55.00
57.00	05700	CT SCAN	0.023148		57.00
58.00	05800	MRI	0.045400		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081498		59.00
60.00	06000	LABORATORY	0.118917		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.055733		62.00
65.00	06500	RESPIRATORY THERAPY	0.138332		65.00
66.00	06600	PHYSICAL THERAPY	0.124140		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.064697		67.00
68.00	06800	SPEECH PATHOLOGY	0.009555		68.00
69.00	06900	ELECTROCARDIOLOGY	0.074800		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.701609		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.164426		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249186		73.00
74.00	07400	RENAL DIALYSIS	0.195669		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0.000000		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.091487		76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	0.271866		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136739		76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0.000000		90.01
91.00	09100	EMERGENCY	0.118041		91.00
91.01	09101	CVILLE OUT	0.040328		91.01
91.02	09102	LAKE HILL OUT	0.000000		91.02
91.03	09103	NUTRITION COUNSELING	1.403763		91.03
91.04	09104	HUNTLEY OP	0.000000		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.238003		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: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 10:52 am	
			Title XIX	Hospital	PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		25,540,352	22,621	25,562,973	30.00
31.00	03100 INTENSIVE CARE UNIT		5,551,053	0	5,551,053	31.00
41.00	04100 SUBPROVIDER - I RF		15,376,337	0	15,376,337	41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		7,525,537	0	7,525,537	50.00
51.00	05100 RECOVERY ROOM		4,639,887	0	4,639,887	51.00
53.00	05300 ANESTHESIOLOGY		411,677	0	411,677	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,322,755	7,174	5,329,929	54.00
54.01	03650 VASCULAR LAB		800,123	0	800,123	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		4,892,741	0	4,892,741	55.00
57.00	05700 CT SCAN		1,230,041	0	1,230,041	57.00
58.00	05800 MRI		725,793	0	725,793	58.00
59.00	05900 CARDIAC CATHETERIZATION		3,068,113	4,420	3,072,533	59.00
60.00	06000 LABORATORY		7,010,314	6,015	7,016,329	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		97,846	0	97,846	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,768,090	0	1,768,090	65.00
66.00	06600 PHYSICAL THERAPY	0	3,128,396	0	3,128,396	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	746,290	0	746,290	67.00
68.00	06800 SPEECH PATHOLOGY	0	29,510	0	29,510	68.00
69.00	06900 ELECTROCARDIOLOGY		1,655,213	2,899	1,658,112	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		15,947,172	0	15,947,172	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		9,346,290	0	9,346,290	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		15,271,822	0	15,271,822	73.00
74.00	07400 RENAL DIALYSIS		744,858	0	744,858	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE		0	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		892,256	0	892,256	76.02
76.03	03951 OCCUPATIONAL HEALTH		0	0	0	76.03
76.97	07697 CARDIAC REHABILITATION		485,749	0	485,749	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY		1,182,145	0	1,182,145	76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT PROCEDURES		0	0	0	90.01
91.00	09100 EMERGENCY		7,138,669	20,182	7,158,851	91.00
91.01	09101 CIVILLE OUT		34,127	0	34,127	91.01
91.02	09102 LAKE HILL OUT		0	0	0	91.02
91.03	09103 NUTRITION COUNSELING		460,812	0	460,812	91.03
91.04	09104 HUNTLEY OP		0	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		3,047,984	0	3,047,984	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		144,071,952	63,311	144,135,263	200.00
201.00	Less Observation Beds		3,047,984		3,047,984	201.00
202.00	Total (see instructions)		141,023,968	63,311	141,087,279	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/29/2018 10:52 am		
			Title XIX			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	81,955,593		81,955,593				30.00
31.00	03100	INTENSIVE CARE UNIT	20,813,753		20,813,753				31.00
41.00	04100	SUBPROVIDER - IRF	38,898,992		38,898,992				41.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	60,617,256	41,648,752	102,266,008	0.073588	0.000000		50.00
51.00	05100	RECOVERY ROOM	19,032,822	18,772,871	37,805,693	0.122730	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	10,205,920	8,346,786	18,552,706	0.022190	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,281,726	21,518,387	29,800,113	0.178615	0.000000		54.00
54.01	03650	VASCULAR LAB	2,746,853	8,944,190	11,691,043	0.068439	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	546,938	13,215,802	13,762,740	0.355506	0.000000		55.00
57.00	05700	CT SCAN	13,249,664	39,887,463	53,137,127	0.023148	0.000000		57.00
58.00	05800	MRI	3,755,964	12,230,792	15,986,756	0.045400	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	16,748,910	20,951,832	37,700,742	0.081381	0.000000		59.00
60.00	06000	LABORATORY	27,878,342	31,123,712	59,002,054	0.118815	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,150,575	605,041	1,755,616	0.055733	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	11,376,795	1,404,665	12,781,460	0.138332	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	15,876,852	9,323,667	25,200,519	0.124140	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	11,439,202	95,993	11,535,195	0.064697	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	3,025,119	63,159	3,088,278	0.009555	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	7,170,660	14,996,722	22,167,382	0.074669	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,469,729	12,259,698	22,729,427	0.701609	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	47,581,661	9,260,203	56,841,864	0.164426	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,627,843	34,659,000	61,286,843	0.249186	0.000000		73.00
74.00	07400	RENAL DIALYSIS	3,589,259	217,465	3,806,724	0.195669	0.000000		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0.000000	0.000000		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	8,656,021	1,096,802	9,752,823	0.091487	0.000000		76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	553	1,786,168	1,786,721	0.271866	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	61,814	8,583,461	8,645,275	0.136739	0.000000		76.98
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	0.000000		90.01
91.00	09100	EMERGENCY	15,815,651	44,831,366	60,647,017	0.117708	0.000000		91.00
91.01	09101	CIVILLE OUT	0	846,245	846,245	0.040328	0.000000		91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	0.000000		91.02
91.03	09103	NUTRITION COUNSELING	504	327,765	328,269	1.403763	0.000000		91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	0.000000		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,546,879	8,259,591	12,806,470	0.238003	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	472,121,850	365,257,598	837,379,448				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	472,121,850	365,257,598	837,379,448				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 10:52 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.073588		50.00
51.00	05100 RECOVERY ROOM	0.122730		51.00
53.00	05300 ANESTHESIOLOGY	0.022190		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178856		54.00
54.01	03650 VASCULAR LAB	0.068439		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.355506		55.00
57.00	05700 CT SCAN	0.023148		57.00
58.00	05800 MRI	0.045400		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.081498		59.00
60.00	06000 LABORATORY	0.118917		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.055733		62.00
65.00	06500 RESPIRATORY THERAPY	0.138332		65.00
66.00	06600 PHYSICAL THERAPY	0.124140		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.064697		67.00
68.00	06800 SPEECH PATHOLOGY	0.009555		68.00
69.00	06900 ELECTROCARDIOLOGY	0.074800		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.701609		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.164426		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.249186		73.00
74.00	07400 RENAL DIALYSIS	0.195669		74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000		76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.091487		76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000		76.03
76.97	07697 CARDIAC REHABILITATION	0.271866		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.136739		76.98
OUTPATIENT SERVICE COST CENTERS				
90.01	09001 OUTPATIENT PROCEDURES	0.000000		90.01
91.00	09100 EMERGENCY	0.118041		91.00
91.01	09101 CIVILLE OUT	0.040328		91.01
91.02	09102 LAKE HILL OUT	0.000000		91.02
91.03	09103 NUTRITION COUNSELING	1.403763		91.03
91.04	09104 HUNTLEY OP	0.000000		91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.238003		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

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

Provider CCN: 14-0217

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

Worksheet C Part II Date/Time Prepared: 5/29/2018 10:52 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,525,537	863,928	6,661,609	0	0	50.00
51.00	05100	RECOVERY ROOM	4,639,887	452,166	4,187,721	0	0	51.00
53.00	05300	ANESTHESIOLOGY	411,677	20,615	391,062	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,322,755	753,925	4,568,830	0	0	54.00
54.01	03650	VASCULAR LAB	800,123	63,470	736,653	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	4,892,741	1,051,016	3,841,725	0	0	55.00
57.00	05700	CT SCAN	1,230,041	74,675	1,155,366	0	0	57.00
58.00	05800	MRI	725,793	69,442	656,351	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,068,113	256,052	2,812,061	0	0	59.00
60.00	06000	LABORATORY	7,010,314	280,283	6,730,031	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	97,846	37,125	60,721	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,768,090	100,576	1,667,514	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,128,396	107,914	3,020,482	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	746,290	290,439	455,851	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	29,510	1,288	28,222	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,655,213	275,571	1,379,642	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,947,172	334,746	15,612,426	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,346,290	195,769	9,150,521	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,271,822	327,648	14,944,174	0	0	73.00
74.00	07400	RENAL DIALYSIS	744,858	24,221	720,637	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	892,256	112,547	779,709	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	485,749	99,100	386,649	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,182,145	95,697	1,086,448	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	7,138,669	784,977	6,353,692	0	0	91.00
91.01	09101	CVILLE OUT	34,127	80,120	-45,993	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	460,812	2,620	458,192	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,047,984	399,999	2,647,985	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	97,604,210	7,155,929	90,448,281	0	0	200.00
201.00		Less Observation Beds	3,047,984	399,999	2,647,985	0	0	201.00
202.00		Total (line 200 minus line 201)	94,556,226	6,755,930	87,800,296	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part II Date/Time Prepared: 5/29/2018 10:52 am
---	--	-----------------------	---------------------------------------	--

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7,525,537	102,266,008	0.073588		50.00
51.00	05100 RECOVERY ROOM	4,639,887	37,805,693	0.122730		51.00
53.00	05300 ANESTHESIOLOGY	411,677	18,552,706	0.022190		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,322,755	29,800,113	0.178615		54.00
54.01	03650 VASCULAR LAB	800,123	11,691,043	0.068439		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	4,892,741	13,762,740	0.355506		55.00
57.00	05700 CT SCAN	1,230,041	53,137,127	0.023148		57.00
58.00	05800 MRI	725,793	15,986,756	0.045400		58.00
59.00	05900 CARDIAC CATHETERIZATION	3,068,113	37,700,742	0.081381		59.00
60.00	06000 LABORATORY	7,010,314	59,002,054	0.118815		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	97,846	1,755,616	0.055733		62.00
65.00	06500 RESPIRATORY THERAPY	1,768,090	12,781,460	0.138332		65.00
66.00	06600 PHYSICAL THERAPY	3,128,396	25,200,519	0.124140		66.00
67.00	06700 OCCUPATIONAL THERAPY	746,290	11,535,195	0.064697		67.00
68.00	06800 SPEECH PATHOLOGY	29,510	3,088,278	0.009555		68.00
69.00	06900 ELECTROCARDIOLOGY	1,655,213	22,167,382	0.074669		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	15,947,172	22,729,427	0.701609		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9,346,290	56,841,864	0.164426		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	15,271,822	61,286,843	0.249186		73.00
74.00	07400 RENAL DIALYSIS	744,858	3,806,724	0.195669		74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000		76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	892,256	9,752,823	0.091487		76.02
76.03	03951 OCCUPATIONAL HEALTH	0	0	0.000000		76.03
76.97	07697 CARDIAC REHABILITATION	485,749	1,786,721	0.271866		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	1,182,145	8,645,275	0.136739		76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT PROCEDURES	0	0	0.000000		90.01
91.00	09100 EMERGENCY	7,138,669	60,647,017	0.117708		91.00
91.01	09101 CIVILLE OUT	34,127	846,245	0.040328		91.01
91.02	09102 LAKE HILL OUT	0	0	0.000000		91.02
91.03	09103 NUTRITION COUNSELING	460,812	328,269	1.403763		91.03
91.04	09104 HUNTLEY OP	0	0	0.000000		91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,047,984	12,806,470	0.238003		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	97,604,210	695,711,110			200.00
201.00	Less Observation Beds	3,047,984	0			201.00
202.00	Total (line 200 minus line 201)	94,556,226	695,711,110			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Prepared: 5/29/2018 10:52 am	
Title XVIII				Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,354,736	0	3,354,736	28,012	119.76	30.00
31.00	INTENSIVE CARE UNIT	452,426		452,426	1,108	408.33	31.00
41.00	SUBPROVIDER - IRF	1,314,594	0	1,314,594	13,008	101.06	41.00
200.00	Total (Lines 30 through 199)	5,121,756		5,121,756	42,128		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,759	1,168,738				
31.00	INTENSIVE CARE UNIT	1,069	436,505				
41.00	SUBPROVIDER - IRF	11,020	1,113,681				
200.00	Total (Lines 30 through 199)	21,848	2,718,924				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/29/2018 10:52 am
--	--	-----------------------	---	---

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	863,928	102,266,008	0.008448	26,805,418	226,452	50.00
51.00	05100	RECOVERY ROOM	452,166	37,805,693	0.011960	8,736,617	104,490	51.00
53.00	05300	ANESTHESIOLOGY	20,615	18,552,706	0.001111	4,355,956	4,839	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	753,925	29,800,113	0.025299	4,242,091	107,321	54.00
54.01	03650	VASCULAR LAB	63,470	11,691,043	0.005429	1,141,094	6,195	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,051,016	13,762,740	0.076367	283,008	21,612	55.00
57.00	05700	CT SCAN	74,675	53,137,127	0.001405	6,280,511	8,824	57.00
58.00	05800	MRI	69,442	15,986,756	0.004344	1,706,462	7,413	58.00
59.00	05900	CARDIAC CATHETERIZATION	256,052	37,700,742	0.006792	7,832,848	53,201	59.00
60.00	06000	LABORATORY	280,283	59,002,054	0.004750	11,948,653	56,756	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,125	1,755,616	0.021146	565,174	11,951	62.00
65.00	06500	RESPIRATORY THERAPY	100,576	12,781,460	0.007869	4,802,253	37,789	65.00
66.00	06600	PHYSICAL THERAPY	107,914	25,200,519	0.004282	2,853,871	12,220	66.00
67.00	06700	OCCUPATIONAL THERAPY	290,439	11,535,195	0.025179	1,112,567	28,013	67.00
68.00	06800	SPEECH PATHOLOGY	1,288	3,088,278	0.000417	695,574	290	68.00
69.00	06900	ELECTROCARDIOLOGY	275,571	22,167,382	0.012431	3,668,326	45,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	334,746	22,729,427	0.014727	4,947,042	72,855	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,769	56,841,864	0.003444	22,359,736	77,007	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,648	61,286,843	0.005346	10,450,378	55,868	73.00
74.00	07400	RENAL DIALYSIS	24,221	3,806,724	0.006363	1,279,625	8,142	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	112,547	9,752,823	0.011540	1,433,768	16,546	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	99,100	1,786,721	0.055465	553	31	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	95,697	8,645,275	0.011069	45,654	505	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	784,977	60,647,017	0.012943	6,302,363	81,571	91.00
91.01	09101	CIVILLE OUT	80,120	846,245	0.094677	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	2,620	328,269	0.007981	504	4	91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	399,999	12,806,470	0.031234	1,812,883	56,624	92.00
200.00		Total (lines 50 through 199)	7,155,929	695,711,110		135,662,929	1,102,120	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/29/2018 10:52 am
---	-----------------------	---	--

Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	9,240	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	44,148	0 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00	
200.00		Total (lines 30 through 199)	0	0	0	53,388	0 200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,240	28,012	0.33	9,759 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	44,148	1,108	39.84	1,069 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	13,008	0.00	11,020 41.00	
200.00		Total (lines 30 through 199)	0	53,388	42,128		21,848 200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,220					30.00
31.00	03100	INTENSIVE CARE UNIT	42,589					31.00
41.00	04100	SUBPROVIDER - I RF	0					41.00
200.00		Total (lines 30 through 199)	45,809					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am
--	-----------------------	---	---

Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	18,481	50.00	
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	26,694	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00	
54.01 03650 VASCULAR LAB	0	0	0	0	0	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MRI	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	18,481	59.00	
60.00 06000 LABORATORY	0	0	0	0	0	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	9,240	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
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	0	0	0	0	74.00	
76.00 03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00	
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02	
76.03 03951 OCCUPATIONAL HEALTH	0	0	0	0	0	76.03	
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98	
OUTPATIENT SERVICE COST CENTERS							
90.01 09001 OUTPATIENT PROCEDURES	0	0	0	0	0	90.01	
91.00 09100 EMERGENCY	0	0	0	0	257,701	91.00	
91.01 09101 C'VILLE OUT	0	0	0	0	0	91.01	
91.02 09102 LAKE HILL OUT	0	0	0	0	0	91.02	
91.03 09103 NUTRITION COUNSELING	0	0	0	0	0	91.03	
91.04 09104 HUNTLEY OP	0	0	0	0	0	91.04	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	1,100	92.00	
200.00 Total (lines 50 through 199)	0	0	0	0	331,697	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am
--	-----------------------	---	---

Cost Center Description		Title XVIII		Hospital		PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	18,481	18,481	102,266,008	0.000181	50.00
51.00	05100	RECOVERY ROOM	0	0	0	37,805,693	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	26,694	26,694	18,552,706	0.001439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,800,113	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	11,691,043	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,762,740	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	53,137,127	0.000000	57.00
58.00	05800	MRI	0	0	0	15,986,756	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,481	18,481	37,700,742	0.000490	59.00
60.00	06000	LABORATORY	0	0	0	59,002,054	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,755,616	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,240	9,240	12,781,460	0.000723	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,200,519	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,535,195	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,088,278	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,167,382	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	22,729,427	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	56,841,864	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,724	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	9,752,823	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,786,721	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	8,645,275	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	257,701	257,701	60,647,017	0.004249	91.00
91.01	09101	CVILLE OUT	0	0	0	846,245	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	328,269	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,100	1,100	12,806,470	0.000086	92.00
200.00		Total (lines 50 through 199)	0	331,697	331,697	695,711,110		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am
--	-----------------------	---	---

Cost Center Description		Title XVIII					Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS	
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000181	26,805,418	4,852	37,655	7	50.00	
51.00	05100 RECOVERY ROOM	0.000000	8,736,617	0	6,210,135	0	51.00	
53.00	05300 ANESTHESIOLOGY	0.001439	4,355,956	6,268	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	4,242,091	0	12,607,205	0	54.00	
54.01	03650 VASCULAR LAB	0.000000	1,141,094	0	3,113,711	0	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	283,008	0	4,557,114	0	55.00	
57.00	05700 CT SCAN	0.000000	6,280,511	0	10,508,347	0	57.00	
58.00	05800 MRI	0.000000	1,706,462	0	3,225,175	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000490	7,832,848	3,838	3,988,881	1,955	59.00	
60.00	06000 LABORATORY	0.000000	11,948,653	0	9,874,484	0	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	565,174	0	133,528	0	62.00	
65.00	06500 RESPIRATORY THERAPY	0.000723	4,802,253	3,472	385,376	279	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	2,853,871	0	125,533	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,112,567	0	36,224	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	695,574	0	13,191	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,668,326	0	5,121,246	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,947,042	0	5,551,336	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,359,736	0	4,769,170	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	10,450,378	0	13,427,841	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	1,279,625	0	113,859	0	74.00	
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	0	0	76.00	
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	1,433,768	0	183,065	0	76.02	
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03	
76.97	07697 CARDIAC REHABILITATION	0.000000	553	0	874,846	0	76.97	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	45,654	0	704,000	0	76.98	
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01	
91.00	09100 EMERGENCY	0.004249	6,302,363	26,779	22,531,721	95,737	91.00	
91.01	09101 CIVILLE OUT	0.000000	0	0	0	0	91.01	
91.02	09102 LAKE HILL OUT	0.000000	0	0	0	0	91.02	
91.03	09103 NUTRITION COUNSELING	0.000000	504	0	0	0	91.03	
91.04	09104 HUNTLEY OP	0.000000	0	0	0	0	91.04	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000086	1,812,883	156	3,148,792	271	92.00	
200.00	Total (lines 50 through 199)		135,662,929	45,365	111,242,435	98,249	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.073588	37,655	0	466	2,771	50.00
51.00	05100	RECOVERY ROOM	0.122730	6,210,135	0	0	762,170	51.00
53.00	05300	ANESTHESIOLOGY	0.022190	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178615	12,607,205	0	0	2,251,836	54.00
54.01	03650	VASCULAR LAB	0.068439	3,113,711	0	0	213,099	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.355506	4,557,114	0	0	1,620,081	55.00
57.00	05700	CT SCAN	0.023148	10,508,347	0	0	243,247	57.00
58.00	05800	MRI	0.045400	3,225,175	0	296	146,423	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081381	3,988,881	0	0	324,619	59.00
60.00	06000	LABORATORY	0.118815	9,874,484	0	0	1,173,237	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.055733	133,528	0	0	7,442	62.00
65.00	06500	RESPIRATORY THERAPY	0.138332	385,376	0	0	53,310	65.00
66.00	06600	PHYSICAL THERAPY	0.124140	125,533	0	0	15,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.064697	36,224	0	0	2,344	67.00
68.00	06800	SPEECH PATHOLOGY	0.009555	13,191	0	0	126	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074669	5,121,246	0	0	382,398	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.701609	5,551,336	0	2	3,894,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.164426	4,769,170	0	0	784,176	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249186	13,427,841	0	55,245	3,346,030	73.00
74.00	07400	RENAL DIALYSIS	0.195669	113,859	0	0	22,279	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.091487	183,065	0	0	16,748	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.271866	874,846	0	0	237,841	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136739	704,000	0	0	96,264	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.117708	22,531,721	0	0	2,652,164	91.00
91.01	09101	CVILLE OUT	0.040328	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1.403763	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.238003	3,148,792	0	0	749,422	92.00
200.00		Subtotal (see instructions)		111,242,435	0	56,009	18,998,478	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		111,242,435	0	56,009	18,998,478	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	34	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03650 VASCULAR LAB	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	13	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13,766	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0	0	76.03
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS				
90.01	09001 OUTPATIENT PROCEDURES	0	0	90.01
91.00	09100 EMERGENCY	0	0	91.00
91.01	09101 CIVILLE OUT	0	0	91.01
91.02	09102 LAKE HILL OUT	0	0	91.02
91.03	09103 NUTRITION COUNSELING	0	0	91.03
91.04	09104 HUNTLEY OP	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	0	13,814	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	13,814	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/29/2018 10:52 am
				Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	863,928	102,266,008	0.008448	56,619	478	50.00
51.00 05100 RECOVERY ROOM	452,166	37,805,693	0.011960	9,504	114	51.00
53.00 05300 ANESTHESIOLOGY	20,615	18,552,706	0.001111	10,200	11	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	753,925	29,800,113	0.025299	430,105	10,881	54.00
54.01 03650 VASCULAR LAB	63,470	11,691,043	0.005429	250,173	1,358	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	1,051,016	13,762,740	0.076367	753	58	55.00
57.00 05700 CT SCAN	74,675	53,137,127	0.001405	524,943	738	57.00
58.00 05800 MRI	69,442	15,986,756	0.004344	264,412	1,149	58.00
59.00 05900 CARDIAC CATHETERIZATION	256,052	37,700,742	0.006792	31,781	216	59.00
60.00 06000 LABORATORY	280,283	59,002,054	0.004750	2,632,062	12,502	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	37,125	1,755,616	0.021146	99,174	2,097	62.00
65.00 06500 RESPIRATORY THERAPY	100,576	12,781,460	0.007869	1,960,607	15,428	65.00
66.00 06600 PHYSICAL THERAPY	107,914	25,200,519	0.004282	9,259,100	39,647	66.00
67.00 06700 OCCUPATIONAL THERAPY	290,439	11,535,195	0.025179	8,082,325	203,505	67.00
68.00 06800 SPEECH PATHOLOGY	1,288	3,088,278	0.000417	1,631,290	680	68.00
69.00 06900 ELECTROCARDIOLOGY	275,571	22,167,382	0.012431	195,915	2,435	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	334,746	22,729,427	0.014727	36,149	532	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	195,769	56,841,864	0.003444	2,104	7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	327,648	61,286,843	0.005346	3,136,932	16,770	73.00
74.00 07400 RENAL DIALYSIS	24,221	3,806,724	0.006363	855,057	5,441	74.00
76.00 03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000	0	0	76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	112,547	9,752,823	0.011540	0	0	76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97 07697 CARDIAC REHABILITATION	99,100	1,786,721	0.055465	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	95,697	8,645,275	0.011069	415	5	76.98
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00 09100 EMERGENCY	784,977	60,647,017	0.012943	182,570	2,363	91.00
91.01 09101 CIVILLE OUT	80,120	846,245	0.094677	0	0	91.01
91.02 09102 LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03 09103 NUTRITION COUNSELING	2,620	328,269	0.007981	0	0	91.03
91.04 09104 HUNTLEY OP	0	0	0.000000	0	0	91.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12,806,470	0.000000	442,821	0	92.00
200.00 Total (lines 50 through 199)	6,755,930	695,711,110		30,095,011	316,415	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	18,481	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	26,694	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	18,481	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	9,240	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	257,701	91.00
91.01	09101	CIVILLE OUT	0	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	330,597	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am
--	---	---	---

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	18,481	18,481	102,266,008	0.000181	50.00
51.00	05100	RECOVERY ROOM	0	0	0	37,805,693	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	26,694	26,694	18,552,706	0.001439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,800,113	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	11,691,043	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,762,740	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	53,137,127	0.000000	57.00
58.00	05800	MRI	0	0	0	15,986,756	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,481	18,481	37,700,742	0.000490	59.00
60.00	06000	LABORATORY	0	0	0	59,002,054	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,755,616	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,240	9,240	12,781,460	0.000723	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,200,519	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,535,195	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,088,278	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,167,382	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	22,729,427	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	56,841,864	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,724	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	9,752,823	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,786,721	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	8,645,275	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	257,701	257,701	60,647,017	0.004249	91.00
91.01	09101	CVILLE OUT	0	0	0	846,245	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	328,269	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,806,470	0.000000	92.00
200.00		Total (lines 50 through 199)	0	330,597	330,597	695,711,110		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000181	56,619	10	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	9,504	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.001439	10,200	15	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	430,105	0	0	0	54.00
54.01	03650 VASCULAR LAB	0.000000	250,173	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	753	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	524,943	0	0	0	57.00
58.00	05800 MRI	0.000000	264,412	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000490	31,781	16	0	0	59.00
60.00	06000 LABORATORY	0.000000	2,632,062	0	35	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	99,174	0	52	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000723	1,960,607	1,418	17	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	9,259,100	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	8,082,325	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	1,631,290	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	195,915	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	36,149	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,104	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	3,136,932	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	855,057	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	415	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.004249	182,570	776	6,651	28	91.00
91.01	09101 CIVILLE OUT	0.000000	0	0	0	0	91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	0	0	91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	442,821	0	0	0	92.00
200.00	Total (lines 50 through 199)		30,095,011	2,235	6,755	28	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 10:52 am
Title XVIII			Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.073588	0	0	165	0	50.00
51.00	05100	RECOVERY ROOM	0.122730	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.022190	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178615	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0.068439	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.355506	0	0	0	0	55.00
57.00	05700	CT SCAN	0.023148	0	0	0	0	57.00
58.00	05800	MRI	0.045400	0	0	58	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081381	0	0	0	0	59.00
60.00	06000	LABORATORY	0.118815	35	0	0	4	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.055733	52	0	0	3	62.00
65.00	06500	RESPIRATORY THERAPY	0.138332	17	0	0	2	65.00
66.00	06600	PHYSICAL THERAPY	0.124140	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.064697	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.009555	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074669	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.701609	0	0	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.164426	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249186	0	0	9,659	0	73.00
74.00	07400	RENAL DIALYSIS	0.195669	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.091487	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.271866	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136739	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.117708	6,651	0	0	783	91.00
91.01	09101	CVILLE OUT	0.040328	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1.403763	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.238003	0	0	0	0	92.00
200.00		Subtotal (see instructions)		6,755	0	9,883	792	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		6,755	0	9,883	792	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 10:52 am
	Title XVIII	Subprovider - IRF	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	12	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03650 VASCULAR LAB	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	3	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,407	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0	76.03
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS			
90.01 09001 OUTPATIENT PROCEDURES	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 C'VILLE OUT	0	0	91.01
91.02 09102 LAKE HILL OUT	0	0	91.02
91.03 09103 NUTRITION COUNSELING	0	0	91.03
91.04 09104 HUNTLEY OP	0	0	91.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	2,423	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	2,423	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part I Date/Time Prepared: 5/29/2018 10:52 am		
Title XIX				Hospital		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	3,354,736	0	3,354,736	28,012	119.76	30.00	
31.00	INTENSIVE CARE UNIT	452,426		452,426	1,108	408.33	31.00	
41.00	SUBPROVIDER - IRF	1,314,594	0	1,314,594	13,008	101.06	41.00	
200.00	Total (Lines 30 through 199)	5,121,756		5,121,756	42,128		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,739	208,263					30.00
31.00	INTENSIVE CARE UNIT	39	15,925					31.00
41.00	SUBPROVIDER - IRF	7	707					41.00
200.00	Total (Lines 30 through 199)	1,785	224,895					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	863,928	102,266,008	0.008448	0	0	50.00
51.00	05100	RECOVERY ROOM	452,166	37,805,693	0.011960	0	0	51.00
53.00	05300	ANESTHESIOLOGY	20,615	18,552,706	0.001111	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	753,925	29,800,113	0.025299	0	0	54.00
54.01	03650	VASCULAR LAB	63,470	11,691,043	0.005429	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,051,016	13,762,740	0.076367	0	0	55.00
57.00	05700	CT SCAN	74,675	53,137,127	0.001405	0	0	57.00
58.00	05800	MRI	69,442	15,986,756	0.004344	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	256,052	37,700,742	0.006792	0	0	59.00
60.00	06000	LABORATORY	280,283	59,002,054	0.004750	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,125	1,755,616	0.021146	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	100,576	12,781,460	0.007869	0	0	65.00
66.00	06600	PHYSICAL THERAPY	107,914	25,200,519	0.004282	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	290,439	11,535,195	0.025179	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,288	3,088,278	0.000417	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	275,571	22,167,382	0.012431	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	334,746	22,729,427	0.014727	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,769	56,841,864	0.003444	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	327,648	61,286,843	0.005346	0	0	73.00
74.00	07400	RENAL DIALYSIS	24,221	3,806,724	0.006363	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	112,547	9,752,823	0.011540	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	99,100	1,786,721	0.055465	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	95,697	8,645,275	0.011069	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	784,977	60,647,017	0.012943	0	0	91.00
91.01	09101	CIVILLE OUT	80,120	846,245	0.094677	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	2,620	328,269	0.007981	0	0	91.03
91.04	09104	HUNTLEY OP	0	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	399,999	12,806,470	0.031234	0	0	92.00
200.00		Total (lines 50 through 199)	7,155,929	695,711,110		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/29/2018 10:52 am
---	-----------------------	---	--

Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	9,240	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	44,148	0 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00	
200.00		Total (lines 30 through 199)	0	0	0	53,388	0 200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,240	28,012	0.33	1,739 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	44,148	1,108	39.84	39 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	13,008	0.00	7 41.00	
200.00		Total (lines 30 through 199)	0	53,388	42,128		1,785 200.00	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	574					30.00
31.00	03100	INTENSIVE CARE UNIT	1,554					31.00
41.00	04100	SUBPROVIDER - I RF	0					41.00
200.00		Total (lines 30 through 199)	2,128					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am
--	-----------------------	---	---

Cost Center Description	Title XIX			Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	18,481	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	26,694	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03650 VASCULAR LAB	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	18,481	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	9,240	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	0	0	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	0	257,701	91.00
91.01 09101 C'VILLE OUT	0	0	0	0	0	91.01
91.02 09102 LAKE HILL OUT	0	0	0	0	0	91.02
91.03 09103 NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04 09104 HUNTLEY OP	0	0	0	0	0	91.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	330,597	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	18,481	18,481	102,266,008	0.000181	50.00
51.00	05100	RECOVERY ROOM	0	0	0	37,805,693	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	26,694	26,694	18,552,706	0.001439	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,800,113	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	11,691,043	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	13,762,740	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	53,137,127	0.000000	57.00
58.00	05800	MRI	0	0	0	15,986,756	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	18,481	18,481	37,700,742	0.000490	59.00
60.00	06000	LABORATORY	0	0	0	59,002,054	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,755,616	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,240	9,240	12,781,460	0.000723	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	25,200,519	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,535,195	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,088,278	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	22,167,382	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	22,729,427	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	56,841,864	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	61,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,724	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	9,752,823	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,786,721	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	8,645,275	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	257,701	257,701	60,647,017	0.004249	91.00
91.01	09101	CIVILLE OUT	0	0	0	846,245	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	328,269	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,806,470	0.000000	92.00
200.00		Total (lines 50 through 199)	0	330,597	330,597	695,711,110		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 10:52 am
--	-----------------------	---------------------------------------	--

Cost Center Description		Title XIX				Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000181	0	0	0	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00	
53.00	05300 ANESTHESIOLOGY	0.001439	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00	
54.01	03650 VASCULAR LAB	0.000000	0	0	0	0	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00	
58.00	05800 MRI	0.000000	0	0	0	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000490	0	0	0	0	59.00	
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00	
65.00	06500 RESPIRATORY THERAPY	0.000723	0	0	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	0	0	76.00	
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02	
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03	
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
OUTPATIENT SERVICE COST CENTERS								
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01	
91.00	09100 EMERGENCY	0.004249	0	0	0	0	91.00	
91.01	09101 CIVILLE OUT	0.000000	0	0	0	0	91.01	
91.02	09102 LAKE HILL OUT	0.000000	0	0	0	0	91.02	
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	0	0	91.03	
91.04	09104 HUNTLEY OP	0.000000	0	0	0	0	91.04	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
200.00	Total (lines 50 through 199)		0	0	0	0	200.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/29/2018 10:52 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,012	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,012	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)		24,672	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)		9,759	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)		25,562,973	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)		25,562,973	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)		25,562,973	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)		912.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,905,771	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)		8,905,771	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 10:52 am
Title XVIII			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	5,551,053	1,108	5,009.98	1,069	5,355,669 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)					19,079,666 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					33,341,106 49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,651,052 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,147,485 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,798,537 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					30,542,569 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)					3,340 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					912.57 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,047,984 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 10:52 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,354,736	25,562,973	0.131234	3,047,984	399,999	90.00
91.00	Nursing School cost	0	25,562,973	0.000000	3,047,984	0	91.00
92.00	Allied health cost	9,240	25,562,973	0.000361	3,047,984	1,100	92.00
93.00	All other Medical Education	0	25,562,973	0.000000	3,047,984	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			13,008 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			13,008 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)			13,008 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)			11,020 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)			15,376,337 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)			15,376,337 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)			15,376,337 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)			1,182.07 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			13,026,411 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)			13,026,411 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 10:52 am	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					0	43.00
44.00	CORONARY CARE UNIT					0	44.00
45.00	BURN INTENSIVE CARE UNIT					0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT					0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					0	47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,520,624	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					16,547,035	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,113,681	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					318,650	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,432,331	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,114,704	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 10:52 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,314,594	15,376,337	0.085495	0	0	90.00
91.00	Nursing School cost	0	15,376,337	0.000000	0	0	91.00
92.00	Allied health cost	0	15,376,337	0.000000	0	0	92.00
93.00	All other Medical Education	0	15,376,337	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/29/2018 10:52 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,012	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,012	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)		24,672	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)		1,739	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)		25,562,973	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)		25,562,973	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)		25,562,973	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)		912.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,586,959	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)		1,586,959	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 10:52 am
Title XIX			Hospital		PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	5,551,053	1,108	5,009.98	39	195,389 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)					1,782,348 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)					226,316 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)					226,316 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,556,032 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)					3,340 87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					912.57 88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,047,984 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 10:52 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,354,736	25,562,973	0.131234	3,047,984	399,999	90.00
91.00	Nursing School cost	0	25,562,973	0.000000	3,047,984	0	91.00
92.00	Allied health cost	9,240	25,562,973	0.000361	3,047,984	1,100	92.00
93.00	All other Medical Education	0	25,562,973	0.000000	3,047,984	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3	
		Title XVIII	Hospital	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		36,077,970	30.00
31.00	03100	INTENSIVE CARE UNIT		9,536,448	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.073588	26,805,418	50.00
51.00	05100	RECOVERY ROOM	0.122730	8,736,617	51.00
53.00	05300	ANESTHESIOLOGY	0.022190	4,355,956	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.178856	4,242,091	54.00
54.01	03650	VASCULAR LAB	0.068439	1,141,094	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.355506	283,008	55.00
57.00	05700	CT SCAN	0.023148	6,280,511	57.00
58.00	05800	MRI	0.045400	1,706,462	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.081498	7,832,848	59.00
60.00	06000	LABORATORY	0.118917	11,948,653	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.055733	565,174	62.00
65.00	06500	RESPIRATORY THERAPY	0.138332	4,802,253	65.00
66.00	06600	PHYSICAL THERAPY	0.124140	2,853,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.064697	1,112,567	67.00
68.00	06800	SPEECH PATHOLOGY	0.009555	695,574	68.00
69.00	06900	ELECTROCARDIOLOGY	0.074800	3,668,326	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.701609	4,947,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.164426	22,359,736	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.249186	10,450,378	73.00
74.00	07400	RENAL DIALYSIS	0.195669	1,279,625	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.091487	1,433,768	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.271866	553	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.136739	45,654	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	90.01
91.00	09100	EMERGENCY	0.118041	6,302,363	91.00
91.01	09101	C'VILLE OUT	0.040328	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	91.02
91.03	09103	NUTRITION COUNSELING	1.403763	504	91.03
91.04	09104	HUNTLEY OP	0.000000	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.238003	1,812,883	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		135,662,929	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)		135,662,929	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/29/2018 10:52 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		5,232		30.00
31.00	03100 INTENSIVE CARE UNIT		251		31.00
41.00	04100 SUBPROVIDER - IRF		32,934,933		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.073588	56,619	4,166	50.00
51.00	05100 RECOVERY ROOM	0.122730	9,504	1,166	51.00
53.00	05300 ANESTHESIOLOGY	0.022190	10,200	226	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.178856	430,105	76,927	54.00
54.01	03650 VASCULAR LAB	0.068439	250,173	17,122	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.355506	753	268	55.00
57.00	05700 CT SCAN	0.023148	524,943	12,151	57.00
58.00	05800 MRI	0.045400	264,412	12,004	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.081498	31,781	2,590	59.00
60.00	06000 LABORATORY	0.118917	2,632,062	312,997	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.055733	99,174	5,527	62.00
65.00	06500 RESPIRATORY THERAPY	0.138332	1,960,607	271,215	65.00
66.00	06600 PHYSICAL THERAPY	0.124140	9,259,100	1,149,425	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.064697	8,082,325	522,902	67.00
68.00	06800 SPEECH PATHOLOGY	0.009555	1,631,290	15,587	68.00
69.00	06900 ELECTROCARDIOLOGY	0.074800	195,915	14,654	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.701609	36,149	25,362	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.164426	2,104	346	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.249186	3,136,932	781,680	73.00
74.00	07400 RENAL DIALYSIS	0.195669	855,057	167,308	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.091487	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	76.03
76.97	07697 CARDIAC REHABILITATION	0.271866	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.136739	415	57	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.118041	182,570	21,551	91.00
91.01	09101 CIVILLE OUT	0.040328	0	0	91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	91.02
91.03	09103 NUTRITION COUNSELING	1.403763	0	0	91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.238003	442,821	105,393	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		30,095,011	3,520,624	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		30,095,011		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		17,318,315	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		5,544,888	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)		547,487	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)		134.85	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.94	31.00
32.00	Sum of lines 30 and 31		23.57	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.66	33.00
34.00	Disproportionate share adjustment (see instructions)		494,989	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 10:52 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		738,925	932,010	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		552,675	234,918	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		787,593		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		24,693,272		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)		24,693,272		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,006,070		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		60,634		53.00
54.00	Special add-on payments for new technologies		7,146		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).		45,809		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		45,365		58.00
59.00	Total (sum of amounts on lines 49 through 58)		26,858,296		59.00
60.00	Primary payer payments		13,441		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		26,844,855		61.00
62.00	Deductibles billed to program beneficiaries		2,306,220		62.00
63.00	Coinurance billed to program beneficiaries		119,098		63.00
64.00	Allowable bad debts (see instructions)		582,888		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		378,877		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		425,757		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		24,798,414		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-45,156		70.93
70.94	HRR adjustment amount (see instructions)		-32,907		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 10:52 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			24,720,351	71.00
71.01	Sequestration adjustment (see instructions)			494,407	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			23,847,050	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			378,894	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			117,181	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)			0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0217

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2018 10:52 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	17,318,315	0	17,318,315		17,318,315	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,544,888	0		5,544,888	5,544,888	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	547,487	0	454,120	93,367	547,487	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	0.0866	0.0866	0.0866	0.0866		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	494,989	0	374,942	120,047	494,989	11.00
11.01	Uncompensated care payments	36.00	787,593	0	719,336	207,352	926,688	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	24,693,272	0	18,727,618	5,965,654	24,693,272	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	24,693,272	0	18,727,618	5,965,654	24,693,272	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,006,070	0	1,527,091	478,979	2,006,070	16.00
17.00	Special add-on payments for new technologies	54.00	7,146	0	1,036	6,110	7,146	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0217

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2018 10:52 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	20,255,745	6,450,743	26,706,488	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,853,663	0	1,401,979	451,684	1,853,663	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	61,763	0	56,555	5,208	61,763	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	0.0489	0.0489	0.0489	0.0489		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	90,644	0	68,557	22,087	90,644	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,006,070	0	1,527,091	478,979	2,006,070	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: 14-0217

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/29/2018 10:52 am

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00				1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	17,318,315	17,318,315		17,318,315	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5,544,888		5,544,888	5,544,888	
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	
2.00	Outlier payments for discharges (see instructions)	2.00	547,487	454,120	93,367	547,487	
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	
4.00	Managed care simulated payments	3.00	0	0	0	0	
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	
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		
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0866	0.0866	0.0866		
11.00	Disproportionate share adjustment (see instructions)	34.00	494,989	374,942	120,047	494,989	
11.01	Uncompensated care payments	36.00	787,593	552,675	234,918	787,593	
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	
13.00	Subtotal (see instructions)	47.00	24,693,272	18,700,052	5,993,220	24,693,272	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,693,272	18,700,052	5,993,220	24,693,272	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,006,070	1,527,091	478,979	2,006,070	
17.00	Special add-on payments for new technologies	54.00	7,146	1,036	6,110	7,146	
17.01	Net organ acquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	
19.00	SUBTOTAL			20,228,179	6,478,309	26,706,488	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0217

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/29/2018 10:52 am

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	1,853,663	1,401,979	451,684	1,853,663	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	61,763	56,555	5,208	61,763	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	0.0489	0.0489	0.0489		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	90,644	68,557	22,087	90,644	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	2,006,070	1,527,091	478,979	2,006,070	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	-45,156	-42,991	-2,165	-45,156	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	-32,907	-32,907	0	-32,907	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: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		13,814	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,900,229	2.00
3.00	OPPS payments		13,006,182	3.00
4.00	Outlier payment (see instructions)		153,733	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		98,249	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		13,814	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		56,009	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)		56,009	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)		56,009	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		42,195	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		13,814	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		13,258,164	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,327,844	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)		10,944,134	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)		10,944,134	30.00
31.00	Primary payer payments		1,215	31.00
32.00	Subtotal (line 30 minus line 31)		10,942,919	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)		404,193	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		262,725	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		288,987	36.00
37.00	Subtotal (see instructions)		11,205,644	37.00
38.00	MSP-LCC reconciliation amount from PS&R		9	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		11,205,635	40.00
40.01	Sequestration adjustment (see instructions)		224,113	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		10,824,220	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		157,302	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,423	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		764	2.00
3.00	OPPS payments		2,007	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		28	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,423	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		9,883	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)		9,883	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)		9,883	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		7,460	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		2,423	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,035	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		11	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)		4,447	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)		4,447	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,447	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		4,447	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		4,447	40.00
40.01	Sequestration adjustment (see instructions)		89	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,640	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-282	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: 14-0217

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2018 10:52 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		23,602,439		10,623,497	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		231,801		181,476	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	08/03/2017	12,810	08/03/2017	19,247	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)		12,810		19,247	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)		23,847,050		10,824,220	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		378,894		157,302	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		24,225,944		10,981,522	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0217
Component CCN: 14-T217

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2018 10:52 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		17,657,757		4,640	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/03/2017	19,444		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		19,444		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,677,201		4,640	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		18,952		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		282	6.02
7.00	Total Medicare program liability (see instructions)		17,696,153		4,358	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: 14-0217

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

Worksheet E-1
Part II
Date/Time Prepared:
5/29/2018 10:52 am

Title XVIII		Hospital	PPS
			1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			18,034,125 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0124 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			91,974 3.00
4.00	Outlier Payments			191,550 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			35.638356 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			18,317,649 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			18,317,649 17.00
18.00	Primary payer payments			13,560 18.00
19.00	Subtotal (line 17 less line 18).			18,304,089 19.00
20.00	Deductibles			190,736 20.00
21.00	Subtotal (line 19 minus line 20)			18,113,353 21.00
22.00	Coinsurance			62,993 22.00
23.00	Subtotal (line 21 minus line 22)			18,050,360 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			7,237 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			4,704 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			4,277 26.00
27.00	Subtotal (sum of lines 23 and 25)			18,055,064 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			2,235 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			18,057,299 32.00
32.01	Sequestration adjustment (see instructions)			361,146 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			17,677,201 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			18,952 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			5,221 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			191,550 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0217

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

Worksheet G

Date/Time Prepared:
5/29/2018 10:52 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	703,607	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	20,245,357	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	3,049,077	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,618,588	0	0	0	9.00
10.00	Due from other funds	6,100,222	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	31,716,851	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,549,055	0	0	0	12.00
13.00	Land improvements	1,964,438	0	0	0	13.00
14.00	Accumulated depreciation	-773,729	0	0	0	14.00
15.00	Buildings	47,066,867	0	0	0	15.00
16.00	Accumulated depreciation	-12,687,012	0	0	0	16.00
17.00	Leasehold improvements	556,799	0	0	0	17.00
18.00	Accumulated depreciation	-156,207	0	0	0	18.00
19.00	Fixed equipment	349,416	0	0	0	19.00
20.00	Accumulated depreciation	-40,235	0	0	0	20.00
21.00	Automobiles and trucks	44,160	0	0	0	21.00
22.00	Accumulated depreciation	-36,204	0	0	0	22.00
23.00	Major movable equipment	18,626,470	0	0	0	23.00
24.00	Accumulated depreciation	-9,486,110	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)	47,977,708	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,113,356	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	134,130	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,247,486	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	83,942,045	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,831,297	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,500	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	5,673	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	15,977,423	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,832,893	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,832,893	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	66,109,152				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)	66,109,152	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	83,942,045	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0217

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

Worksheet G-1

Date/Time Prepared:
5/29/2018 10:52 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		61,865,820		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,243,332			2.00
3.00	Total (sum of line 1 and line 2)		66,109,152		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		66,109,152		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		66,109,152		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0217

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2018 10:52 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	81,955,593		81,955,593	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	38,898,992		38,898,992	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)	120,854,585		120,854,585	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	20,813,753		20,813,753	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)	20,813,753		20,813,753	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	141,668,338		141,668,338	17.00
18.00	Ancillary services	330,453,511	310,992,630	641,446,141	18.00
19.00	Outpatient services	0	54,264,967	54,264,967	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	MISC INCOME	0	860	860	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	472,121,849	365,258,457	837,380,306	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		142,456,761		29.00
30.00	BALANCING AMOUNT	1			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)		1		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)		142,456,762		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0217

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

Worksheet G-3

Date/Time Prepared:
5/29/2018 10:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	837,380,306	1.00
2.00	Less contractual allowances and discounts on patients' accounts	694,236,780	2.00
3.00	Net patient revenues (line 1 minus line 2)	143,143,526	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	142,456,762	4.00
5.00	Net income from service to patients (line 3 minus line 4)	686,764	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	6,363	6.00
7.00	Income from investments	112,273	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	485,275	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	326,916	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	2,625,741	24.00
25.00	Total other income (sum of lines 6-24)	3,556,568	25.00
26.00	Total (line 5 plus line 25)	4,243,332	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,243,332	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0217	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/29/2018 10:52 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,853,663	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		61,763	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)		70.63	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)		3.63	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		19.94	8.00
9.00	Sum of lines 7 and 8		23.57	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.89	10.00
11.00	Disproportionate share adjustment (see instructions)		90,644	11.00
12.00	Total prospective capital payments (see instructions)		2,006,070	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