

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: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/23/2018 3:39 pm
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PART I - COST REPORT STATUS

Provider use only

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

Contractor use only

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

6. Date Received:
 7. Contractor No.

8. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN

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

Date: 5/23/2018 Time: 3:39 pm

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 SOUTH SUBURBAN HOSPITAL (14-0250) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

 CORPORATE DIRECTOR OF REIMBURSEMENT
 Title

 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-133,735	-62,623	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I						4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	22,050	0		0	7.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	-111,685	-62,623	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 2:00 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 178TH STREET AND KEDZIE AVE			PO Box:							1.00
2.00	City: HAZELCREST			State: IL		Zip Code: 60429-		County: COOK			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	
								V	XVIII	XIX	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SOUTH SUBURBAN HOSPITAL	140250	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF		SOUTH SUBURBAN NURSING UNIT	145599	16974		05/01/1988	N	P	O	9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2017	12/31/2017		20.00	
21.00	Type of Control (see instructions)						2			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			1,496	3,355	0	0	3,946	95		24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0			25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 2:00 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0				35.00
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)						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			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			47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N			48.00
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.						57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N	0.00		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 2:00 pm			
						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N				80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N				81.00		
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N				85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N				87.00		
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y		90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N		91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N		93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N		94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.06		
Rural Providers									
105.00	Does this hospital qualify as a CAH?		N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N				108.00		
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N		N		N		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: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 2:00 pm	
		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:	326,369	3,049,000	904,015	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H036	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/23/2018 2:00 pm							
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: ADVOCATE HEALTHCARE	Contractor's Name: NATIONAL GOVT SERV		Contractor's Number: 06101		141.00							
142.00	Street: 3075 HIGHLAND PARKWAY	PO Box:				142.00							
143.00	City: DOWNERS GROVE	State: IL		Zip Code: 60515		143.00							
						1.00							
144.00	Are provider based physicians' costs included in Worksheet A?						Y 144.00						
						1.00							
						2.00							
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						Y 145.00						
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N 146.00						
						1.00							
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N 147.00						
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N 148.00						
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N 149.00						
		Part A		Part B		Title V		Title XIX					
		1.00		2.00		3.00		4.00					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)													
155.00	Hospital	N		N		N		N 155.00					
156.00	Subprovider - IPF	N		N		N		N 156.00					
157.00	Subprovider - IRF	N		N		N		N 157.00					
158.00	SUBPROVIDER							158.00					
159.00	SNF	N		N		N		N 159.00					
160.00	HOME HEALTH AGENCY	N		N		N		N 160.00					
161.00	CMHC							N 161.00					
161.10	CORF			N		N		N 161.10					
						1.00							
Multi campus													
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N 165.00						
		Name		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		166.00				
						1.00							
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y		167.00				
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0		168.00				
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01				
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99		169.00				
						Beginni ng		Endi ng					
						1.00		2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						01/01/2017		12/31/2017 170.00				
						1.00		2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N		0 171.00				

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 2:00 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			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.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
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	05/17/2018	Y	05/17/2018
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: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 2:00 pm	
		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	GARY		WILLIAMS	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVOCATE HEALTH CARE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5650		GARY.WILLIAMS@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/23/2018 2:00 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SR REIMBURSEMENT SPECIALIST		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0250

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	213	77,745	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)		213	77,745	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00 CORONARY CARE UNIT	32.00	0	0	0.00	0	9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	0	0	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		233	85,045	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	41	11,193		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		274				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: 14-0250

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	13,406	3,358	36,902			1.00
2.00 HMO and other (see instructions)	10,781	3,946				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	13,406	3,358	36,902			7.00
8.00 INTENSIVE CARE UNIT	2,202	866	5,594			8.00
9.00 CORONARY CARE UNIT	0	0	0			9.00
10.00 BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		534	1,623			13.00
14.00 Total (see instructions)	15,608	4,758	44,119	0.00	1,052.81	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER		0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	2,673	0	5,914	0.00	25.49	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	1,080			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,078.30	27.00
28.00 Observation Bed Days		262	7,669			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	188	261			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: 14-0250

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

Worksheet S-3
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	3,317	473	10,302	1.00
2.00 HMO and other (see instructions)				2,312	1,313		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		3,317	473	10,302	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	0	0	17.00
18.00 SUBPROVIDER	0.00	0			0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00						19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days					0		33.00
33.01 LTCH site neutral days and discharges					0		33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0250

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

Worksheet S-3
Part II
Date/Time Prepared:
5/23/2018 2:00 pm

	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	74,779,687	0	74,779,687	2,249,010.31	33.25
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		577,049	0	577,049	3,301.05	174.81
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		188,602	0	188,602	1,676.75	112.48
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	1,501,523	24,321	1,525,844	53,164.49	28.70
10.00	Excluded area salaries (see instructions)		0	22,500	22,500	230.44	97.64
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		3,862,943	0	3,862,943	64,719.09	59.69
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		254,871	0	254,871	1,324.56	192.42
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,828,306	0	7,828,306	115,086.00	68.02
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)		18,635,213	0	18,635,213		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		393,846	0	393,846		
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		151,807	0	151,807		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		49,616	0	49,616		
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)		1,369,660	0	1,369,660		
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	1,515,824	-1,264,516	251,308	7,592.00	33.10
27.00	Administrative & General	5.00	7,378,529	-374,694	7,003,835	145,212.00	48.23

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0250

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

Worksheet S-3
Part II
Date/Time Prepared:
5/23/2018 2:00 pm

		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.)		962,601	0	962,601	5,370.00	179.26	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,145,288	27,699	2,172,987	75,419.00	28.81	30.00
31.00	Laundry & Linen Service	8.00	149,557	1,011	150,568	9,407.00	16.01	31.00
32.00	Housekeeping	9.00	1,549,687	14,346	1,564,033	104,389.00	14.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,801,339	-716,069	1,085,270	62,954.00	17.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	740,028	740,028	43,896.00	16.86	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	4,839,224	121,438	4,960,662	105,036.00	47.23	38.00
39.00	Central Services and Supply	14.00	343,073	69,498	412,571	19,620.00	21.03	39.00
40.00	Pharmacy	15.00	2,905,922	47,462	2,953,384	61,486.00	48.03	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	1,005,364	3,926	1,009,290	25,466.00	39.63	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0250

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

Worksheet S-3
Part III
Date/Time Prepared:
5/23/2018 2:00 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	75,553,686	0	75,553,686	2,252,703.56	33.54	1.00
2.00	Excluded area salaries (see instructions)	1,501,523	46,821	1,548,344	53,394.93	29.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	74,052,163	-46,821	74,005,342	2,199,308.63	33.65	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,946,120	0	11,946,120	181,129.65	65.95	4.00
5.00	Subtotal wage-related costs (see inst.)	20,156,680	0	20,156,680	0.00	27.24	5.00
6.00	Total (sum of lines 3 thru 5)	106,154,963	-46,821	106,108,142	2,380,438.28	44.58	6.00
7.00	Total overhead cost (see instructions)	24,596,408	-1,329,871	23,266,537	665,847.00	34.94	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part IV Date/Time Prepared: 5/23/2018 2:00 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		1,421,641	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)		1,215,129	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		75,761	6.00
7.00	Employee Managed Care Program Administration Fees		852,244	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		5,210,424	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		1,851,896	9.00
10.00	Dental, Hearing and Vision Plan		235,165	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		85,741	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)		525,079	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,654,300	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		5,278,470	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		183,014	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))		197,817	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		443,802	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		19,230,483	24.00
Part B - Other than Core Related Cost				
25.00	OTHER EMPLOYEE COSTS		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part V Date/Time Prepared: 5/23/2018 2:00 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,862,943	19,230,483	1.00
2.00	Hospital	3,862,943	18,635,213	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	393,846	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	201,424	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0250

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

Worksheet S-7

Date/Time Prepared:
5/23/2018 2:00 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	0	0	0	3.00
4.00	RUL	0	0	0	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	11	0	11	6.00
7.00	RHX	8	0	8	7.00
8.00	RHL	0	0	0	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	24	0	24	12.00
13.00	RUB	69	0	69	13.00
14.00	RUA	657	0	657	14.00
15.00	RVC	122	0	122	15.00
16.00	RVB	193	0	193	16.00
17.00	RVA	956	0	956	17.00
18.00	RHC	45	0	45	18.00
19.00	RHB	36	0	36	19.00
20.00	RHA	265	0	265	20.00
21.00	RMC	7	0	7	21.00
22.00	RMB	0	0	0	22.00
23.00	RMA	96	0	96	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	1	0	1	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	36	0	36	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	6	0	6	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	31	0	31	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	0	0	0	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	0	0	0	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	28	0	28	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	5	0	5	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	45	0	45	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	0	0	0	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	26	0	26	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	4	0	4	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0250

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

Worksheet S-7

Date/Time Prepared:
5/23/2018 2:00 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)		
		1.00	2.00	3.00	4.00		
69.00		PE2	0	0	0	69.00	
70.00		PE1	0	0	0	70.00	
71.00		PD2	0	0	0	71.00	
72.00		PD1	0	0	0	72.00	
73.00		PC2	0	0	0	73.00	
74.00		PC1	0	0	0	74.00	
75.00		PB2	0	0	0	75.00	
76.00		PB1	0	0	0	76.00	
77.00		PA2	0	0	0	77.00	
78.00		PA1	1	0	1	78.00	
199.00		AAA	1	0	1	199.00	
200.00	TOTAL		2,673	0	2,673	200.00	
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)		
				1.00	2.00		
SNF SERVICES							
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).			16974	16974	201.00	
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?		
			1.00	2.00	3.00		
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)							
202.00	Staffing			1,501,523	25.15	Y	202.00
203.00	Recruitment			0	0.00		203.00
204.00	Retention of employees			0	0.00		204.00
205.00	Training			0	0.00		205.00
206.00	OTHER (SPECIFY)			0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)			5,970,135			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/23/2018 2:00 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.214761	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		17,413,374	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	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		162,610,986	6.00	
7.00	Medicaid cost (line 1 times line 6)		34,922,498	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)		17,509,124	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)		17,509,124	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)	7,107,658	715,364	7,823,022	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,526,448	715,364	2,241,812	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,526,448	715,364	2,241,812	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		15,255,854	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,118,760	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,721,169	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		13,534,685	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,509,131	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,750,943	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		23,260,067	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0250

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

Worksheet A
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,562,744	5,562,744	3,885,509	9,448,253
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,515,824	14,128,340	15,644,164	-1,302,369	14,341,795
5.00	00500	ADMINISTRATIVE & GENERAL	7,378,529	47,968,605	55,347,134	-960,859	54,386,275
7.00	00700	OPERATION OF PLANT	2,145,288	4,657,964	6,803,252	-132,256	6,670,996
8.00	00800	LAUNDRY & LINEN SERVICE	149,557	754,008	903,565	-95	903,470
9.00	00900	HOUSEKEEPING	1,549,687	990,769	2,540,456	-9,105	2,531,351
10.00	01000	DIETARY	1,801,339	1,569,691	3,371,030	-1,399,747	1,971,283
11.00	01100	CAFETERIA	0	0	0	1,384,890	1,384,890
13.00	01300	NURSING ADMINISTRATION	4,839,224	565,680	5,404,904	107,445	5,512,349
14.00	01400	CENTRAL SERVICES & SUPPLY	343,073	424,225	767,298	-137,967	629,331
15.00	01500	PHARMACY	2,905,922	13,143,240	16,049,162	-12,614,535	3,434,627
16.00	01600	MEDICAL RECORDS & LIBRARY	0	128,479	128,479	-1,211	127,268
17.00	01700	SOCIAL SERVICE	1,005,364	99,291	1,104,655	3,877	1,108,532
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,220,291	7,456,691	27,676,982	-2,890,978	24,786,004
31.00	03100	INTENSIVE CARE UNIT	4,241,591	1,598,037	5,839,628	-602,465	5,237,163
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	506,214	696,232	1,202,446	-54,518	1,147,928
44.00	04400	SKILLED NURSING FACILITY	1,501,523	216,063	1,717,586	-67,228	1,650,358
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,730,980	15,306,252	20,037,232	-13,451,955	6,585,277
53.00	05300	ANESTHESIOLOGY	151,442	284,630	436,072	884,255	1,320,327
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,750,207	2,028,163	6,778,370	-1,470,480	5,307,890
56.00	05600	RADIOISOTOPE	405,718	669,317	1,075,035	-628,273	446,762
56.01	05601	ULTRASOUND	675,202	139,975	815,177	-72,088	743,089
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	1,281,344	4,593,262	5,874,606	-4,192,513	1,682,093
60.00	06000	LABORATORY	0	6,671,073	6,671,073	-1,364	6,669,709
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,068,585	1,068,585	-634,513	434,072
64.00	06400	INTRAVENOUS THERAPY	332,658	208,832	541,490	-179,476	362,014
65.00	06500	RESPIRATORY THERAPY	1,451,584	432,155	1,883,739	-150,543	1,733,196
66.00	06600	PHYSICAL THERAPY	94,304	3,952,991	4,047,295	-1,224,201	2,823,094
67.00	06700	OCCUPATIONAL THERAPY	0	240	240	1,183,599	1,183,839
68.00	06800	SPEECH PATHOLOGY	303,475	27,640	331,115	890	332,005
69.00	06900	ELECTROCARDIOLOGY	903,552	211,369	1,114,921	120,218	1,235,139
70.00	07000	ELECTROENCEPHALOGRAPHY	93,298	43,148	136,446	-15,252	121,194
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,580,375	12,580,375
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,207,295	10,207,295
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,032,456	14,032,456
74.00	07400	RENAL DIALYSIS	478,387	268,246	746,633	-211,644	534,989
75.00	07500	ASC (NON-DISTINCT PART)	1,513,389	383,420	1,896,809	-212,585	1,684,224
76.00	03560	PULMONARY FUNCTION TESTING	75,618	7,877	83,495	-1,856	81,639
76.97	07697	CARDIAC REHABILITATION	305,576	51,000	356,576	52,424	409,000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	2,265,298	1,244,442	3,509,740	-882,313	2,627,427
91.00	09100	EMERGENCY	4,864,229	5,150,320	10,014,549	-963,331	9,051,218
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
93.00	04950	SLEEP LAB	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	1,268,423	1,268,423	0	1,268,423
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	22,500	22,500
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,779,687	143,971,419	218,751,106	13	218,751,119

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017	Worksheet A Date/Time Prepared: 5/23/2018 2:00 pm			
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	123,945	123,945	0	123,945	190.00
190.01	19001	NONREIMBURSABLE HHA	0	110,902	110,902	-13	110,889	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	74,779,687	144,206,266	218,985,953	0	218,985,953	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0250

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

Worksheet A
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1,592,772	11,041,025	1.00
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3,441,347	17,783,142	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-23,255,148	31,131,127	5.00
7.00	00700 OPERATION OF PLANT	-115,981	6,555,015	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	903,470	8.00
9.00	00900 HOUSEKEEPING	-326	2,531,025	9.00
10.00	01000 DIETARY	-451,818	1,519,465	10.00
11.00	01100 CAFETERIA	0	1,384,890	11.00
13.00	01300 NURSING ADMINISTRATION	-15,895	5,496,454	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-58	629,273	14.00
15.00	01500 PHARMACY	-13,340	3,421,287	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1,922	125,346	16.00
17.00	01700 SOCIAL SERVICE	-22,223	1,086,309	17.00
23.00	02301 PARAMEDICAL ED PRGM	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-2,691,552	22,094,452	30.00
31.00	03100 INTENSIVE CARE UNIT	-5,133	5,232,030	31.00
32.00	03200 CORONARY CARE UNIT	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	-582,500	565,428	43.00
44.00	04400 SKILLED NURSING FACILITY	-291	1,650,067	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-40,845	6,544,432	50.00
53.00	05300 ANESTHESIOLOGY	-1,104,360	215,967	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-13,526	5,294,364	54.00
56.00	05600 RADIOISOTOPE	-10,321	436,441	56.00
56.01	05601 ULTRASOUND	0	743,089	56.01
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	1,682,093	59.00
60.00	06000 LABORATORY	-362,670	6,307,039	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	434,072	62.00
64.00	06400 INTRAVENOUS THERAPY	-3,233	358,781	64.00
65.00	06500 RESPIRATORY THERAPY	-12,268	1,720,928	65.00
66.00	06600 PHYSICAL THERAPY	-435	2,822,659	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,183,839	67.00
68.00	06800 SPEECH PATHOLOGY	-588	331,417	68.00
69.00	06900 ELECTROCARDIOLOGY	-3,572	1,231,567	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	121,194	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,580,375	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	10,207,295	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14,032,456	73.00
74.00	07400 RENAL DIALYSIS	0	534,989	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	1,684,224	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	81,639	76.00
76.97	07697 CARDIAC REHABILITATION	-59	408,941	76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	-67,892	2,559,535	90.00
91.00	09100 EMERGENCY	-3,336,904	5,714,314	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00	04950 SLEEP LAB	0	0	93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF	0	0	112.00
113.00	11300 INTEREST EXPENSE	-1,268,423	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	-22,500	0	114.00
118.00	11800 SUBTOTALS (SUM OF LINES 1 through 117)	-28,369,664	190,381,455	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	123,945	190.00
190.01	19001 NONREIMBURSABLE HHA	-110,902	-13	190.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0250

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

Worksheet A
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6.00	7.00	
194.00	07950	FUND RAISING	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-28,480,566	190,505,387	194.00
					200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	740,028	644,862	1.00
	TOTALS		740,028	644,862	
B - PATIENT DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,032,456	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
	TOTALS		0	14,032,456	
C - PHYSICIAN COMPENSATION					
1.00	UTILIZATION REVIEW-SNF	114.00	22,500	0	1.00
	TOTALS		22,500	0	
D - CENTRAL PROCESSING					
1.00	CENTRAL SERVICES & SUPPLY	14.00	58,572	0	1.00
	TOTALS		58,572	0	
E - MEDICAL DIRECTORS - PHYSICIANS					
1.00	ADULTS & PEDIATRICS	30.00	74,454	0	1.00
2.00	OPERATING ROOM	50.00	167,994	155,900	2.00
3.00	ANESTHESIOLOGY	53.00	0	1,152,785	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	32,000	4.00
5.00	RESPIRATORY THERAPY	65.00	89,340	0	5.00
6.00	ELECTROCARDIOLOGY	69.00	38,000	0	6.00
7.00	RENAL DIALYSIS	74.00	16,200	0	7.00
8.00	CLINIC	90.00	10,000	54,890	8.00
9.00	EMERGENCY	91.00	64,000	38,500	9.00
	TOTALS		459,988	1,434,075	
G - CONTRACTED OR NURSE ASSISTANTS					
1.00	OPERATING ROOM	50.00	0	155,900	1.00
	TOTALS		0	155,900	
H - EQUIP DEPR					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	3,885,509	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

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
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
TOTALS			0	3,885,509	
I - OCCUPATIONAL THERAPY					
1.00	OCCUPATIONAL THERAPY	67.00	0	1,183,804	1.00
TOTALS			0	1,183,804	
J - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	22,787,670	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
35.00		0.00	0	0	35.00
TOTALS			0	22,787,670	
K - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	10,207,295	1.00
TOTALS			0	10,207,295	
L - CARDIOLOGY ADMINISTRATION					
1.00	CARDIAC CATHETERIZATION	59.00	247,574	24,521	1.00
2.00	ELECTROCARDIOLOGY	69.00	177,128	17,544	2.00
3.00	CARDIAC REHABILITATION	76.97	59,904	5,933	3.00
TOTALS			484,606	47,998	
M - MANAGEMENT INCENTIVES					
1.00	ADMINISTRATIVE & GENERAL	5.00	621,316	0	1.00
2.00	OPERATION OF PLANT	7.00	16,969	0	2.00
3.00	DIETARY	10.00	8,643	0	3.00
4.00	NURSING ADMINISTRATION	13.00	103,054	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	9,021	0	5.00
6.00	PHARMACY	15.00	37,626	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	47,773	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10,948	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	11,029	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	36,534	0	10.00
11.00	RESPIRATORY THERAPY	65.00	6,766	0	11.00
12.00	ASC (NON-DIAGNOSTIC PART)	75.00	10,569	0	12.00
13.00	EMERGENCY	91.00	10,948	0	13.00
TOTALS			931,196	0	

RECLASSIFICATIONS

Provider CCN: 14-0250

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

Worksheet A-6

Date/Time Prepared:
5/23/2018 2:00 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
N - ASSOCIATE BONUSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	29,656	0	1.00	
2.00	OPERATION OF PLANT	7.00	10,730	0	2.00	
3.00	LAUNDRY & LINEN SERVICE	8.00	1,011	0	3.00	
4.00	HOUSEKEEPING	9.00	14,346	0	4.00	
5.00	DIETARY	10.00	15,316	0	5.00	
6.00	NURSING ADMINISTRATION	13.00	18,384	0	6.00	
7.00	CENTRAL SERVICES & SUPPLY	14.00	1,905	0	7.00	
8.00	PHARMACY	15.00	9,836	0	8.00	
9.00	SOCIAL SERVICE	17.00	3,926	0	9.00	
10.00	ADULTS & PEDIATRICS	30.00	85,086	0	10.00	
11.00	INTENSIVE CARE UNIT	31.00	16,481	0	11.00	
12.00	NURSERY	43.00	1,710	0	12.00	
13.00	SKILLED NURSING FACILITY	44.00	13,292	0	13.00	
14.00	OPERATING ROOM	50.00	20,488	0	14.00	
15.00	ANESTHESIOLOGY	53.00	700	0	15.00	
16.00	RADIOLOGY-DIAGNOSTIC	54.00	24,956	0	16.00	
17.00	RADIOLOGY	56.00	1,205	0	17.00	
18.00	ULTRASOUND	56.01	2,720	0	18.00	
19.00	CARDIAC CATHETERIZATION	59.00	4,277	0	19.00	
20.00	INTRAVENOUS THERAPY	64.00	1,283	0	20.00	
21.00	RESPIRATORY THERAPY	65.00	7,074	0	21.00	
22.00	PHYSICAL THERAPY	66.00	350	0	22.00	
23.00	SPEECH PATHOLOGY	68.00	1,205	0	23.00	
24.00	ELECTROCARDIOLOGY	69.00	5,597	0	24.00	
25.00	ELECTROENCEPHALOGRAPHY	70.00	933	0	25.00	
26.00	RENAL DIALYSIS	74.00	1,594	0	26.00	
27.00	ASC (NON-DISTINCT PART)	75.00	7,423	0	27.00	
28.00	PULMONARY FUNCTION TESTING	76.00	311	0	28.00	
29.00	CARDIAC REHABILITATION	76.97	1,244	0	29.00	
30.00	CLINIC	90.00	8,941	0	30.00	
31.00	EMERGENCY	91.00	21,340	0	31.00	
TOTALS			333,320	0		
500.00	Grand Total: Increases		3,030,210	54,379,569	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0250

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

Worksheet A-6
Date/Time Prepared:
5/23/2018 2:00 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA COSTS						
1.00	DIETARY	10.00	740,028	644,862	0	1.00
	TOTALS		740,028	644,862		
B - PATIENT DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37,056	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	278	0	2.00
3.00	DIETARY	10.00	0	202	0	3.00
4.00	NURSING ADMINISTRATION	13.00	0	14	0	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	57	0	5.00
6.00	PHARMACY	15.00	0	12,472,891	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	205,165	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	57,442	0	8.00
9.00	NURSERY	43.00	0	859	0	9.00
10.00	SKILLED NURSING FACILITY	44.00	0	6,349	0	10.00
11.00	OPERATING ROOM	50.00	0	76,061	0	11.00
12.00	ANESTHESIOLOGY	53.00	0	71,951	0	12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	40,668	0	13.00
14.00	RADIOLOGY	56.00	0	629,478	0	14.00
15.00	ULTRASOUND	56.01	0	71	0	15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	8,740	0	16.00
17.00	INTRAVENOUS THERAPY	64.00	0	39,336	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	303	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	24	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	2,893	0	20.00
21.00	RENAL DIALYSIS	74.00	0	730	0	21.00
22.00	ASC (NON-DISTINCT PART)	75.00	0	96,839	0	22.00
23.00	CLINIC	90.00	0	31,074	0	23.00
24.00	EMERGENCY	91.00	0	253,975	0	24.00
	TOTALS		0	14,032,456		
C - PHYSICIAN COMPENSATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	22,500	0	0	1.00
	TOTALS		22,500	0		
D - CENTRAL PROCESSING						
1.00	ADMINISTRATIVE & GENERAL	5.00	58,572	0	0	1.00
	TOTALS		58,572	0		
E - MEDICAL DIRECTORS - PHYSICIANS						
1.00	ADMINISTRATIVE & GENERAL	5.00	459,988	331,290	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,102,785	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
	TOTALS		459,988	1,434,075		
G - CONTRACTED OR NURSE ASSISTANTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	155,900	0	1.00
	TOTALS		0	155,900		
H - EQUIP DEPR						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	44,345	9	1.00
2.00	OPERATION OF PLANT	7.00	0	159,357	0	2.00
3.00	HOUSEKEEPING	9.00	0	9,913	0	3.00
4.00	DIETARY	10.00	0	28,338	0	4.00
5.00	NURSING ADMINISTRATION	13.00	0	13,202	0	5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	140,760	0	6.00
7.00	PHARMACY	15.00	0	157,962	0	7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,048	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	649,508	0	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	40,637	0	10.00
11.00	NURSERY	43.00	0	34,132	0	11.00
12.00	SKILLED NURSING FACILITY	44.00	0	1,886	0	12.00
13.00	OPERATING ROOM	50.00	0	1,006,228	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	60,302	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	865,330	0	15.00
16.00	ULTRASOUND	56.01	0	26,256	0	16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	216,515	0	17.00
18.00	LABORATORY	60.00	0	1,317	0	18.00
19.00	INTRAVENOUS THERAPY	64.00	0	9,069	0	19.00
20.00	RESPIRATORY THERAPY	65.00	0	26,082	0	20.00
21.00	PHYSICAL THERAPY	66.00	0	6,969	0	21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	205	0	22.00
23.00	ELECTROCARDIOLOGY	69.00	0	96,265	0	23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,303	0	24.00

RECLASSIFICATIONS

Provider CCN: 14-0250

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

Worksheet A-6

Date/Time Prepared:
5/23/2018 2:00 pm

Decreases							
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
25.00	RENAL DIALYSIS	74.00	0	42,777	0		25.00
26.00	ASC (NON-DISTINCT PART)	75.00	0	56,371	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	10,486	0		27.00
28.00	CLINIC	90.00	0	15,804	0		28.00
29.00	EMERGENCY	91.00	0	155,142	0		29.00
	TOTALS		0	3,885,509			
I - OCCUPATIONAL THERAPY							
1.00	PHYSICAL THERAPY	66.00	0	1,183,804	0		1.00
	TOTALS		0	1,183,804			
J - MEDICAL SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	797	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	6,354	0		2.00
3.00	OPERATION OF PLANT	7.00	0	598	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	1,106	0		4.00
5.00	HOUSEKEEPING	9.00	0	13,538	0		5.00
6.00	DIETARY	10.00	0	10,276	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	777	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	66,648	0		8.00
9.00	PHARMACY	15.00	0	31,144	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	163	0		10.00
11.00	SOCIAL SERVICE	17.00	0	49	0		11.00
12.00	ADULTS & PEDIATRICS	30.00	0	1,140,833	0		12.00
13.00	INTENSIVE CARE UNIT	31.00	0	531,815	0		13.00
14.00	NURSERY	43.00	0	21,237	0		14.00
15.00	SKILLED NURSING FACILITY	44.00	0	83,314	0		15.00
16.00	OPERATING ROOM	50.00	0	12,869,948	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	136,977	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	657,972	0		18.00
19.00	ULTRASOUND	56.01	0	48,481	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	4,243,630	0		20.00
21.00	LABORATORY	60.00	0	47	0		21.00
22.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	634,513	0		22.00
23.00	INTRAVENOUS THERAPY	64.00	0	132,354	0		23.00
24.00	RESPIRATORY THERAPY	65.00	0	227,338	0		24.00
25.00	PHYSICAL THERAPY	66.00	0	33,754	0		25.00
26.00	SPEECH PATHOLOGY	68.00	0	315	0		26.00
27.00	ELECTROCARDIOLOGY	69.00	0	18,893	0		27.00
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,882	0		28.00
29.00	RENAL DIALYSIS	74.00	0	185,931	0		29.00
30.00	ASC (NON-DISTINCT PART)	75.00	0	77,367	0		30.00
31.00	PULMONARY FUNCTION TESTING	76.00	0	2,167	0		31.00
32.00	CARDIAC REHABILITATION	76.97	0	4,171	0		32.00
33.00	CLINIC	90.00	0	909,266	0		33.00
34.00	EMERGENCY	91.00	0	689,002	0		34.00
35.00	NONREIMBURSABLE HHA	190.01	0	13	0		35.00
	TOTALS		0	22,787,670			
K - IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,207,295	0		1.00
	TOTALS		0	10,207,295			
L - RADIOLOGY ADMINISTRATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	484,606	47,998	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		484,606	47,998			
M - MANAGEMENT INCENTIVES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	931,196	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
	TOTALS		931,196	0	0		

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	N - ASSOCIATE BONUSES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	333,320	0	0		1.00	
2.00		0.00	0	0	0		2.00	
3.00		0.00	0	0	0		3.00	
4.00		0.00	0	0	0		4.00	
5.00		0.00	0	0	0		5.00	
6.00		0.00	0	0	0		6.00	
7.00		0.00	0	0	0		7.00	
8.00		0.00	0	0	0		8.00	
9.00		0.00	0	0	0		9.00	
10.00		0.00	0	0	0		10.00	
11.00		0.00	0	0	0		11.00	
12.00		0.00	0	0	0		12.00	
13.00		0.00	0	0	0		13.00	
14.00		0.00	0	0	0		14.00	
15.00		0.00	0	0	0		15.00	
16.00		0.00	0	0	0		16.00	
17.00		0.00	0	0	0		17.00	
18.00		0.00	0	0	0		18.00	
19.00		0.00	0	0	0		19.00	
20.00		0.00	0	0	0		20.00	
21.00		0.00	0	0	0		21.00	
22.00		0.00	0	0	0		22.00	
23.00		0.00	0	0	0		23.00	
24.00		0.00	0	0	0		24.00	
25.00		0.00	0	0	0		25.00	
26.00		0.00	0	0	0		26.00	
27.00		0.00	0	0	0		27.00	
28.00		0.00	0	0	0		28.00	
29.00		0.00	0	0	0		29.00	
30.00		0.00	0	0	0		30.00	
31.00		0.00	0	0	0		31.00	
	TOTALS		333,320	0	0			
500.00	Grand Total: Decreases		3,030,210	54,379,569			500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0250

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

Worksheet A-7
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	714,843	0	0	0	1.00
2.00	Land Improvements	5,497,166	0	0	0	2.00
3.00	Buildings and Fixtures	133,556,287	2,786,158	0	2,786,158	3.00
4.00	Building Improvements	3,308,192	0	0	0	4.00
5.00	Fixed Equipment	54,610,621	6,805,135	0	6,805,135	5.00
6.00	Movable Equipment	25,793	22,739	0	22,739	6.00
7.00	HIT designated Assets	802,434	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	198,515,336	9,614,032	0	9,614,032	8.00
9.00	Reconciling Items	-4,050,935	-1,819,456	0	-1,819,456	9.00
10.00	Total (line 8 minus line 9)	202,566,271	11,433,488	0	11,433,488	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	714,843	0			1.00
2.00	Land Improvements	5,497,166	3,412,922			2.00
3.00	Buildings and Fixtures	136,342,445	56,926,742			3.00
4.00	Building Improvements	3,308,192	269,880			4.00
5.00	Fixed Equipment	61,394,795	34,660,749			5.00
6.00	Movable Equipment	48,532	25,793			6.00
7.00	HIT designated Assets	802,434	631,147			7.00
8.00	Subtotal (sum of lines 1-7)	208,108,407	95,927,233			8.00
9.00	Reconciling Items	-5,870,391	0			9.00
10.00	Total (line 8 minus line 9)	213,978,798	95,927,233			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0250

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

Worksheet A-7
Part II
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,562,744	0	0	0	0	1.00
3.00	Total (sum of lines 1-2)	5,562,744	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,562,744				
3.00	Total (sum of lines 1-2)	0	5,562,744				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0250

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

Worksheet A-7
Part III
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	11,041,025	0	1.00
3.00	Total (sum of lines 1-2)	0	0	0	11,041,025	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	11,041,025	1.00
3.00	Total (sum of lines 1-2)	0	0	0	0	11,041,025	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0250

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

Worksheet A-8

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst.	A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	*** Cost Center Deleted ***	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	-84,170	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-6,987,392	0		0.00	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	-5,952,105	0		0.00	0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		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)	A	-22,500	0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT			0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	*** Cost Center Deleted ***	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)		-582,225	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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0250

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

Worksheet A-8

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.00 OTHER NONALLOWABLE EXPENSES	A	-7,879	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01 OTHER NONALLOWABLE EXPENSES	A	-629,151	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 OTHER NONALLOWABLE EXPENSES	A	-115,981	OPERATION OF PLANT	7.00	0	33.02
33.03 OTHER NONALLOWABLE EXPENSES	A	-326	HOUSEKEEPING	9.00	0	33.03
33.04 OTHER NONALLOWABLE EXPENSES	A	-2,798	DIETARY	10.00	0	33.04
33.05 OTHER NONALLOWABLE EXPENSES	A	-15,895	NURSING ADMINISTRATION	13.00	0	33.05
33.06 OTHER NONALLOWABLE EXPENSES	A	-58	CENTRAL SERVICES & SUPPLY	14.00	0	33.06
33.07 OTHER NONALLOWABLE EXPENSES	A	-13,340	PHARMACY	15.00	0	33.07
33.08 OTHER NONALLOWABLE EXPENSES	A	-22,223	SOCIAL SERVICE	17.00	0	33.08
33.09 OTHER NONALLOWABLE EXPENSES	A	-44,312	ADULTS & PEDIATRICS	30.00	0	33.09
33.10 OTHER NONALLOWABLE EXPENSES	A	-5,133	INTENSIVE CARE UNIT	31.00	0	33.10
33.11 OTHER NONALLOWABLE EXPENSES	A	-291	SKILLED NURSING FACILITY	44.00	0	33.11
33.12 OTHER NONALLOWABLE EXPENSES	A	-40,845	OPERATING ROOM	50.00	0	33.12
33.13 OTHER NONALLOWABLE EXPENSES	A	-1,575	ANESTHESIOLOGY	53.00	0	33.13
33.14 OTHER NONALLOWABLE EXPENSES	A	-1,776	RADIOLOGY-DIAGNOSTIC	54.00	0	33.14
33.15 OTHER NONALLOWABLE EXPENSES	A	-3,233	INTRAVENOUS THERAPY	64.00	0	33.15
33.16 OTHER NONALLOWABLE EXPENSES	A	-12,268	RESPIRATORY THERAPY	65.00	0	33.16
33.17 OTHER NONALLOWABLE EXPENSES	A	-315	PHYSICAL THERAPY	66.00	0	33.17
33.18 OTHER NONALLOWABLE EXPENSES	A	-588	SPEECH PATHOLOGY	68.00	0	33.18
33.19 OTHER NONALLOWABLE EXPENSES	A	-59	CARDIAC REHABILITATION	76.97	0	33.19
33.20 OTHER NONALLOWABLE EXPENSES	A	-22,349	CLINIC	90.00	0	33.20
33.21 OTHER NONALLOWABLE EXPENSES	A	-99,812	EMERGENCY	91.00	0	33.21
33.22 OTHER NONALLOWABLE EXPENSES		0		0.00	0	33.22
34.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
34.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.05
36.05 AHP FEE	A	-1,564,401	ADMINISTRATIVE & GENERAL	5.00	0	36.05
37.00 BOOKED DEPR TO MC	A	-403	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	37.00
37.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.01
38.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	38.00
39.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
39.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.05
40.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.03
41.00 ADVERTISING COSTS	A	-2,053	ADMINISTRATIVE & GENERAL	5.00	0	41.00
45.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.01
45.02 BOOKED INTEREST EXPENSE	A	-1,268,423	INTEREST EXPENSE	113.00	0	45.02
45.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.06
45.07 HHA EXPENSES	A	-110,902	NONREIMBURSABLE HHA	190.01	0	45.07
45.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.10
45.15 PUBLIC AID ASSESSMENT	A	-9,300,856	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.16
45.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.17
45.18 OTHER INCOME	B	-680,011	ADMINISTRATIVE & GENERAL	5.00	0	45.18
45.19 OTHER INCOME	B	-449,020	DIETARY	10.00	0	45.19
45.24 OTHER INCOME	B	-1,922	MEDICAL RECORDS & LIBRARY	16.00	0	45.24
45.25 OTHER INCOME	B	-11,750	RADIOLOGY-DIAGNOSTIC	54.00	0	45.25
45.27 OTHER INCOME	B	-10,321	RADIOISOTOPE	56.00	0	45.27
45.28 OTHER INCOME	B	-362,670	LABORATORY	60.00	0	45.28
45.30 OTHER INCOME	B	-120	PHYSICAL THERAPY	66.00	0	45.30
45.34 OTHER INCOME	B	-3,572	ELECTROCARDIOLOGY	69.00	0	45.34
45.35 OTHER INCOME	B	-45,543	CLINIC	90.00	0	45.35
45.36 OTHER INCOME		0		0.00	0	45.36
45.37 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.37
45.38 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.38
45.39 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.39

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0250

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

Worksheet A-8

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
45.40 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.40
45.41 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.41
45.42 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.42
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-28,480,566				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: 14-0250

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

Worksheet A-8-1

Date/Time Prepared:
5/23/2018 2:00 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	3,469,478	11,148,402 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION IT	4,098,762	7,414,344 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE PERSONNEL ALLOC	3,449,226	0 3.00
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE DEPR	1,593,175	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	0		0	12,610,641	18,562,746 5.00

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

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

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

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

6.00	B	0.00	ADVOCATE HEALTH	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0250

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

Worksheet A-8-1

Date/Time Prepared:
5/23/2018 2:00 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-7,678,924	0		1.00
2.00	-3,315,582	0		2.00
3.00	3,449,226	0		3.00
4.00	1,593,175	9		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	-5,952,105			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0250

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

Worksheet A-8-2

Date/Time Prepared:
5/23/2018 2:00 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	2,065,015	2,065,015	0	197,500	0	1.00
2.00	43.00	AGGREGATE-NURSERY	582,500	582,500	0	197,500	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,102,785	1,102,785	0	239,400	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	3,237,092	3,237,092	0	197,500	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,987,392	6,987,392	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	2,065,015		1.00
2.00	43.00	AGGREGATE-NURSERY	0	0	0	582,500		2.00
3.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,102,785		3.00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	3,237,092		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	6,987,392		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	11,041,025	11,041,025				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	17,783,142	17,879	17,801,021			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	31,131,127	1,199,075	1,673,363	34,003,565	34,003,565	5.00
7.00 00700	OPERATION OF PLANT	6,555,015	2,705,439	519,172	9,779,626	2,124,849	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	903,470	28,135	35,974	967,579	210,229	8.00
9.00 00900	HOUSEKEEPING	2,531,025	125,674	373,680	3,030,379	658,420	9.00
10.00 01000	DIETARY	1,519,465	202,099	259,294	1,980,858	430,387	10.00
11.00 01100	CAFETERIA	1,384,890	195,929	176,808	1,757,627	381,885	11.00
13.00 01300	NURSING ADMINISTRATION	5,496,454	103,106	1,185,206	6,784,766	1,474,146	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	629,273	70,008	98,572	797,853	173,352	14.00
15.00 01500	PHARMACY	3,421,287	107,549	705,625	4,234,461	920,034	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	125,346	113,307	0	238,653	51,853	16.00
17.00 01700	SOCIAL SERVICE	1,086,309	10,832	241,141	1,338,282	290,773	17.00
23.00 02301	PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	22,094,452	2,237,294	4,880,586	29,212,332	6,346,995	30.00
31.00 03100	INTENSIVE CARE UNIT	5,232,030	364,080	1,019,959	6,616,069	1,437,493	31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	565,428	46,288	121,354	733,070	159,276	43.00
44.00 04400	SKILLED NURSING FACILITY	1,650,067	410,724	364,556	2,425,347	526,962	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	6,544,432	633,856	1,175,363	8,353,651	1,815,023	50.00
53.00 05300	ANESTHESIOLOGY	215,967	10,969	36,350	263,286	57,205	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	5,294,364	625,136	1,149,615	7,069,115	1,535,928	54.00
56.00 05600	RADIOISOTOPE	436,441	73,820	97,222	607,483	131,990	56.00
56.01 05601	ULTRASOUND	743,089	0	161,970	905,059	196,645	56.01
57.00 05700	CT SCAN	0	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	1,682,093	102,969	366,312	2,151,374	467,435	59.00
60.00 06000	LABORATORY	6,307,039	262,098	0	6,569,137	1,427,296	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	434,072	30,109	0	464,181	100,854	62.00
64.00 06400	INTRAVENOUS THERAPY	358,781	5,567	79,786	444,134	96,498	64.00
65.00 06500	RESPIRATORY THERAPY	1,720,928	58,875	371,466	2,151,269	467,413	65.00
66.00 06600	PHYSICAL THERAPY	2,822,659	152,356	22,615	2,997,630	651,304	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,183,839	23,555	0	1,207,394	262,334	67.00
68.00 06800	SPEECH PATHOLOGY	331,417	5,567	72,794	409,778	89,034	68.00
69.00 06900	ELECTROCARDIOLOGY	1,231,567	23,912	268,613	1,524,092	331,144	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	121,194	24,625	22,514	168,333	36,574	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,580,375	0	0	12,580,375	2,733,376	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	10,207,295	0	0	10,207,295	2,217,770	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	14,032,456	0	0	14,032,456	3,048,874	73.00
74.00 07400	RENAL DIALYSIS	534,989	41,736	118,548	695,273	151,064	74.00
75.00 07500	ASC (NON-DISTINCT PART)	1,684,224	214,329	365,879	2,264,432	492,000	75.00
76.00 03560	PULMONARY FUNCTION TESTING	81,639	8,665	18,141	108,445	23,562	76.00
76.97 07697	CARDIAC REHABILITATION	408,941	82,403	87,618	578,962	125,793	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00 09000	CLINIC	2,559,535	208,379	545,753	3,313,667	719,970	90.00
91.00 09100	EMERGENCY	5,714,314	483,996	1,185,172	7,383,482	1,604,231	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00 04950	SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910	CORF	0	0	0	0	0	99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00 08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		4.00	4A	5.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	190,381,455	11,010,340	17,801,021	190,350,770	33,969,971	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	123,945	17,084	0	141,029	30,642	190.00
190.01	19001 NONREIMBURSABLE HHA	-13	13,601	0	13,588	2,952	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950 FUND RAISING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	190,505,387	11,041,025	17,801,021	190,505,387	34,003,565	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	11,904,475				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,050	1,224,858			8.00
9.00	00900	HOUSEKEEPING	210,165	0	3,898,964		9.00
10.00	01000	DIETARY	337,970	0	113,137	2,862,352	10.00
11.00	01100	CAFETERIA	327,652	0	109,683	0	11.00
13.00	01300	NURSING ADMINISTRATION	172,424	0	57,720	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,074	0	39,191	0	14.00
15.00	01500	PHARMACY	179,853	0	60,207	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	189,483	0	63,430	0	16.00
17.00	01700	SOCIAL SERVICE	18,114	0	6,064	0	17.00
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,741,426	903,397	1,252,455	2,111,136	30.00
31.00	03100	INTENSIVE CARE UNIT	608,850	136,947	203,815	320,029	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	77,407	39,733	25,912	92,851	43.00
44.00	04400	SKILLED NURSING FACILITY	686,854	144,781	229,927	338,336	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,059,997	0	354,838	0	50.00
53.00	05300	ANESTHESIOLOGY	18,343	0	6,140	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,045,414	0	349,956	0	54.00
56.00	05600	RADIOISOTOPE	123,448	0	41,325	0	56.00
56.01	05601	ULTRASOUND	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	172,195	0	57,643	0	59.00
60.00	06000	LABORATORY	438,306	0	146,725	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	50,352	0	16,855	0	62.00
64.00	06400	INTRAVENOUS THERAPY	9,309	0	3,116	0	64.00
65.00	06500	RESPIRATORY THERAPY	98,456	0	32,959	0	65.00
66.00	06600	PHYSICAL THERAPY	254,784	0	85,290	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,392	0	13,186	0	67.00
68.00	06800	SPEECH PATHOLOGY	9,309	0	3,116	0	68.00
69.00	06900	ELECTROCARDIOLOGY	39,988	0	13,386	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,180	0	13,785	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	69,795	0	23,364	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	358,422	0	119,983	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	14,491	0	4,851	0	76.00
76.97	07697	CARDIAC REHABILITATION	137,802	0	46,130	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	348,471	0	116,652	0	90.00
91.00	09100	EMERGENCY	809,385	0	270,945	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
100.00	10000	I & R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,853,161	1,224,858	3,881,786	2,862,352	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,569	0	9,564	0	190.00
190.01	19001	NONREIMBURSABLE HHA	22,745	0	7,614	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
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Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
194.00	07950 FUND RAISING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	11,904,475	1,224,858	3,898,964	2,862,352	2,576,847	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part I Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description			NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	8,695,935					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,144,676				14.00
15.00	01500	PHARMACY	0	39,352	5,557,075			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	543,419		16.00
17.00	01700	SOCIAL SERVICE	204,677	1,141	0	0	1,901,142	17.00
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,828,896	251,563	81,467	74,915	1,402,194	30.00
31.00	03100	INTENSIVE CARE UNIT	836,611	34,413	22,809	16,930	212,559	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	99,895	2,256	341	1,363	61,670	43.00
44.00	04400	SKILLED NURSING FACILITY	308,380	2,465	2,521	3,651	224,719	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	927,923	567,475	30,202	59,942	0	50.00
53.00	05300	ANESTHESIOLOGY	29,552	2,854	28,570	14,129	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	93,536	31,093	16,148	76,517	0	54.00
56.00	05600	RADIOISOTOPE	0	212	249,953	5,754	0	56.00
56.01	05601	ULTRASOUND	0	11,139	28	7,422	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	237,260	13,557	3,470	12,414	0	59.00
60.00	06000	LABORATORY	0	0	0	40,801	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,758	0	62.00
64.00	06400	INTRAVENOUS THERAPY	69,458	3,322	15,620	681	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,421	27,363	120	7,246	0	65.00
66.00	06600	PHYSICAL THERAPY	19,735	15,338	10	9,583	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	4,119	0	67.00
68.00	06800	SPEECH PATHOLOGY	59,501	3,136	0	1,152	0	68.00
69.00	06900	ELECTROCARDIOLOGY	184,418	15,650	1,149	12,885	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	18,638	18,333	0	722	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,742	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	20,021	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	4,952,737	74,476	0	73.00
74.00	07400	RENAL DIALYSIS	93,785	0	290	2,307	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	307,963	14,360	38,453	6,591	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	148	0	0	191	0	76.00
76.97	07697	CARDIAC REHABILITATION	35,089	9,716	0	823	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	301,896	23,363	12,339	10,936	0	90.00
91.00	09100	EMERGENCY	1,018,153	56,335	100,848	62,348	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,695,935	1,144,436	5,557,075	543,419	1,901,142	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	240	0	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	0	0	0	0	190.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE		
		13.00	14.00	15.00	16.00	17.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,695,935	1,144,676	5,557,075	543,419	1,901,142	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
23.00	02301	PARAMEDICAL ED PRGM	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	50,058,682	0	50,058,682
31.00	03100	INTENSIVE CARE UNIT	0	10,624,560	0	10,624,560
32.00	03200	CORONARY CARE UNIT	0	0	0	0
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	0	1,314,956	0	1,314,956
44.00	04400	SKILLED NURSING FACILITY	0	4,957,577	0	4,957,577
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,374,212	0	13,374,212
53.00	05300	ANESTHESIOLOGY	0	426,424	0	426,424
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,418,374	0	10,418,374
56.00	05600	RADIOISOTOPE	0	1,177,135	0	1,177,135
56.01	05601	ULTRASOUND	0	1,148,565	0	1,148,565
57.00	05700	CT SCAN	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	3,179,288	0	3,179,288
60.00	06000	LABORATORY	0	8,622,265	0	8,622,265
60.01	06001	BLOOD LABORATORY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	635,000	0	635,000
64.00	06400	INTRAVENOUS THERAPY	0	656,065	0	656,065
65.00	06500	RESPIRATORY THERAPY	0	2,870,087	0	2,870,087
66.00	06600	PHYSICAL THERAPY	0	4,037,621	0	4,037,621
67.00	06700	OCCUPATIONAL THERAPY	0	1,526,425	0	1,526,425
68.00	06800	SPEECH PATHOLOGY	0	587,732	0	587,732
69.00	06900	ELECTROCARDIOLOGY	0	2,169,599	0	2,169,599
70.00	07000	ELECTROENCEPHALOGRAPHY	0	301,495	0	301,495
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,326,493	0	15,326,493
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	12,445,086	0	12,445,086
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,108,543	0	22,108,543
74.00	07400	RENAL DIALYSIS	0	1,056,571	0	1,056,571
75.00	07500	ASC (NON-DISTINCT PART)	0	3,666,069	0	3,666,069
76.00	03560	PULMONARY FUNCTION TESTING	0	154,855	0	154,855
76.97	07697	CARDIAC REHABILITATION	0	949,609	0	949,609
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	0	4,942,556	0	4,942,556
91.00	09100	EMERGENCY	0	11,512,600	0	11,512,600
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
93.00	04950	SLEEP LAB	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0
113.00	11300	INTEREST EXPENSE	0	0	0	0
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	190,248,444	0	190,248,444

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0250

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

Worksheet B
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description			PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			23.00	24.00	25.00	26.00		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	210,044	0	210,044		190.00
190.01	19001	NONREIMBURSABLE HHA	0	46,899	0	46,899		190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	FUND RAISING	0	0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	190,505,387	0	190,505,387		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0250

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

Worksheet B Part II Date/Time Prepared: 5/23/2018 2:00 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT							1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	111	17,879	17,990	17,990	17,990		4.00
5.00 00500 ADMINISTRATIVE & GENERAL	305,504	1,199,075	1,504,579	1,504,579	1,688	1,506,267	5.00
7.00 00700 OPERATION OF PLANT	3,650	2,705,439	2,709,089	2,709,089	524	94,129	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	28,135	28,135	28,135	36	9,313	8.00
9.00 00900 HOUSEKEEPING	0	125,674	125,674	125,674	377	29,167	9.00
10.00 01000 DIETARY	32,736	202,099	234,835	234,835	262	19,066	10.00
11.00 01100 CAFETERIA	0	195,929	195,929	195,929	178	16,917	11.00
13.00 01300 NURSING ADMINISTRATION	0	103,106	103,106	103,106	1,196	65,303	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	121,240	70,008	191,248	191,248	99	7,679	14.00
15.00 01500 PHARMACY	100,838	107,549	208,387	208,387	712	40,757	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	50,616	113,307	163,923	163,923	0	2,297	16.00
17.00 01700 SOCIAL SERVICE	0	10,832	10,832	10,832	243	12,881	17.00
23.00 02301 PARAMEDICAL ED PRGM	0	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	11,382	2,237,294	2,248,676	2,248,676	4,957	281,107	30.00
31.00 03100 INTENSIVE CARE UNIT	0	364,080	364,080	364,080	1,029	63,680	31.00
32.00 03200 CORONARY CARE UNIT	0	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0	0	0	42.00
43.00 04300 NURSERY	0	46,288	46,288	46,288	122	7,056	43.00
44.00 04400 SKILLED NURSING FACILITY	0	410,724	410,724	410,724	368	23,344	44.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	6,650	633,856	640,506	640,506	1,186	80,404	50.00
53.00 05300 ANESTHESIOLOGY	0	10,969	10,969	10,969	37	2,534	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	625,136	625,136	625,136	1,160	68,040	54.00
56.00 05600 RADIOISOTOPE	0	73,820	73,820	73,820	98	5,847	56.00
56.01 05601 ULTRASOUND	4,000	0	4,000	4,000	163	8,711	56.01
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	2,294	102,969	105,263	105,263	369	20,707	59.00
60.00 06000 LABORATORY	0	262,098	262,098	262,098	0	63,228	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	30,109	30,109	30,109	0	4,468	62.00
64.00 06400 INTRAVENOUS THERAPY	0	5,567	5,567	5,567	80	4,275	64.00
65.00 06500 RESPIRATORY THERAPY	32,133	58,875	91,008	91,008	375	20,706	65.00
66.00 06600 PHYSICAL THERAPY	0	152,356	152,356	152,356	23	28,852	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	23,555	23,555	23,555	0	11,621	67.00
68.00 06800 SPEECH PATHOLOGY	0	5,567	5,567	5,567	73	3,944	68.00
69.00 06900 ELECTROCARDIOLOGY	0	23,912	23,912	23,912	271	14,669	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	24,625	24,625	24,625	23	1,620	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	121,086	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	98,245	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	135,062	73.00
74.00 07400 RENAL DIALYSIS	0	41,736	41,736	41,736	120	6,692	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	214,329	214,329	214,329	369	21,795	75.00
76.00 03560 PULMONARY FUNCTION TESTING	0	8,665	8,665	8,665	18	1,044	76.00
76.97 07697 CARDIAC REHABILITATION	0	82,403	82,403	82,403	88	5,573	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	208,379	208,379	208,379	551	31,894	90.00
91.00 09100 EMERGENCY	1,722	483,996	485,718	485,718	1,195	71,066	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
93.00 04950 SLEEP LAB	0	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	0	111.00
112.00 08600 OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	0	112.00
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	0	114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	672,876	11,010,340	11,683,216	11,683,216	17,990	1,504,779	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0250

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

Worksheet B
Part II
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		NEW BLDG & FIXT					
	0	1.00		2A	4.00	5.00	
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,084	17,084	0	1,357	190.00
190.01 19001	NONREIMBURSABLE HHA	0	13,601	13,601	0	131	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	FUND RAISING	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments		0	0			200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	672,876	11,041,025	11,713,901	17,990	1,506,267	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 2:00 pm		
Cost Center Description				OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA
				7.00	8.00	9.00	10.00	11.00
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	2,803,742					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,081	48,565				8.00
9.00	00900	HOUSEKEEPING	49,498	0	204,716			9.00
10.00	01000	DIETARY	79,599	0	5,940	339,702		10.00
11.00	01100	CAFETERIA	77,169	0	5,759	0	295,952	11.00
13.00	01300	NURSING ADMINISTRATION	40,609	0	3,031	0	23,762	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	27,573	0	2,058	0	1,976	14.00
15.00	01500	PHARMACY	42,359	0	3,161	0	14,147	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,627	0	3,330	0	0	16.00
17.00	01700	SOCIAL SERVICE	4,266	0	318	0	4,834	17.00
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	881,181	35,820	65,759	250,549	97,830	30.00
31.00	03100	INTENSIVE CARE UNIT	143,396	5,430	10,701	37,981	20,449	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	18,231	1,575	1,361	11,019	2,433	43.00
44.00	04400	SKILLED NURSING FACILITY	161,768	5,740	12,072	40,153	7,309	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	249,650	0	18,631	0	23,564	50.00
53.00	05300	ANESTHESIOLOGY	4,320	0	322	0	729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	246,216	0	18,375	0	23,048	54.00
56.00	05600	RADIOISOTOPE	29,075	0	2,170	0	1,949	56.00
56.01	05601	ULTRASOUND	0	0	0	0	3,247	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	40,555	0	3,027	0	7,344	59.00
60.00	06000	LABORATORY	103,230	0	7,704	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,859	0	885	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2,192	0	164	0	1,600	64.00
65.00	06500	RESPIRATORY THERAPY	23,188	0	1,730	0	7,447	65.00
66.00	06600	PHYSICAL THERAPY	60,007	0	4,478	0	453	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,278	0	692	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,192	0	164	0	1,459	68.00
69.00	06900	ELECTROCARDIOLOGY	9,418	0	703	0	5,385	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,699	0	724	0	451	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,438	0	1,227	0	2,377	74.00
75.00	07500	ASC (NON-DISTINCT PART)	84,416	0	6,300	0	7,335	75.00
76.00	03560	PULMONARY FUNCTION TESTING	3,413	0	255	0	364	76.00
76.97	07697	CARDIAC REHABILITATION	32,455	0	2,422	0	1,757	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	82,072	0	6,125	0	10,942	90.00
91.00	09100	EMERGENCY	190,626	0	14,226	0	23,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,791,656	48,565	203,814	339,702	295,952	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,729	0	502	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	5,357	0	400	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0250			Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
			7.00	8.00	9.00	10.00	11.00		
194.00	07950	FUND RAISING	0	0	0	0	0		194.00
200.00		Cross Foot Adjustments							200.00
201.00		Negative Cost Centers	0	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,803,742	48,565	204,716	339,702	295,952		202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description			NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	237,007					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	230,633				14.00
15.00	01500	PHARMACY	0	7,929	317,452			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	214,177		16.00
17.00	01700	SOCIAL SERVICE	5,579	230	0	0	39,183	17.00
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	104,352	50,686	4,654	29,575	28,899	30.00
31.00	03100	INTENSIVE CARE UNIT	22,803	6,934	1,303	6,684	4,381	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,723	454	19	538	1,271	43.00
44.00	04400	SKILLED NURSING FACILITY	8,405	497	144	1,441	4,632	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	25,291	114,336	1,725	23,664	0	50.00
53.00	05300	ANESTHESIOLOGY	805	575	1,632	5,578	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,549	6,265	922	29,853	0	54.00
56.00	05600	RADIOISOTOPE	0	43	14,278	2,272	0	56.00
56.01	05601	ULTRASOUND	0	2,244	2	2,930	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,467	2,732	198	4,901	0	59.00
60.00	06000	LABORATORY	0	0	0	16,107	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	1,089	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1,893	669	892	269	0	64.00
65.00	06500	RESPIRATORY THERAPY	557	5,513	7	2,861	0	65.00
66.00	06600	PHYSICAL THERAPY	538	3,090	1	3,783	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,626	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,622	632	0	455	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,026	3,153	66	5,087	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	508	3,694	0	285	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5,030	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	7,904	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	282,929	29,401	0	73.00
74.00	07400	RENAL DIALYSIS	2,556	0	17	911	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	8,394	2,893	2,197	2,602	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	4	0	0	75	0	76.00
76.97	07697	CARDIAC REHABILITATION	956	1,958	0	325	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,228	4,707	705	4,317	0	90.00
91.00	09100	EMERGENCY	27,751	11,351	5,761	24,614	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	237,007	230,585	317,452	214,177	39,183	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	48	0	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	0	0	0	0	190.01

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 2:00 pm		
Cost Center	Description	PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00	
5.00	00500	ADMINISTRATIVE & GENERAL				5.00	
7.00	00700	OPERATION OF PLANT				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE				8.00	
9.00	00900	HOUSEKEEPING				9.00	
10.00	01000	DIETARY				10.00	
11.00	01100	CAFETERIA				11.00	
13.00	01300	NURSING ADMINISTRATION				13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00	
15.00	01500	PHARMACY				15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00	
17.00	01700	SOCIAL SERVICE				17.00	
23.00	02301	PARAMEDICAL ED PRGM	0			23.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,084,045	0	4,084,045	30.00	
31.00	03100	INTENSIVE CARE UNIT	688,851	0	688,851	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	42.00	
43.00	04300	NURSERY	93,090	0	93,090	43.00	
44.00	04400	SKILLED NURSING FACILITY	676,597	0	676,597	44.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,178,957	0	1,178,957	50.00	
53.00	05300	ANESTHESIOLOGY	27,501	0	27,501	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,021,564	0	1,021,564	54.00	
56.00	05600	RADIOISOTOPE	129,552	0	129,552	56.00	
56.01	05601	ULTRASOUND	21,297	0	21,297	56.01	
57.00	05700	CT SCAN	0	0	0	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	191,563	0	191,563	59.00	
60.00	06000	LABORATORY	452,367	0	452,367	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	60.01	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,410	0	48,410	62.00	
64.00	06400	INTRAVENOUS THERAPY	17,601	0	17,601	64.00	
65.00	06500	RESPIRATORY THERAPY	153,392	0	153,392	65.00	
66.00	06600	PHYSICAL THERAPY	253,581	0	253,581	66.00	
67.00	06700	OCCUPATIONAL THERAPY	46,772	0	46,772	67.00	
68.00	06800	SPEECH PATHOLOGY	16,108	0	16,108	68.00	
69.00	06900	ELECTROCARDIOLOGY	67,690	0	67,690	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	41,629	0	41,629	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,116	0	126,116	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	106,149	0	106,149	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	447,392	0	447,392	73.00	
74.00	07400	RENAL DIALYSIS	72,074	0	72,074	74.00	
75.00	07500	ASC (NON-DISTINCT PART)	350,630	0	350,630	75.00	
76.00	03560	PULMONARY FUNCTION TESTING	13,838	0	13,838	76.00	
76.97	07697	CARDIAC REHABILITATION	127,937	0	127,937	76.97	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00	
90.00	09000	CLINIC	357,920	0	357,920	90.00	
91.00	09100	EMERGENCY	856,069	0	856,069	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00	
93.00	04950	SLEEP LAB	0	0	0	93.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	99.10	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00	
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	111.00	
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	112.00	
113.00	11300	INTEREST EXPENSE	0	0	0	113.00	
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	114.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,668,692	0	11,668,692	118.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prepared: 5/23/2018 2:00 pm		
Cost Center Description	PARAMEDICAL ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,720	0	25,720	190.00
190.01	19001	NONREIMBURSABLE HHA	19,489	0	19,489	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	194.00
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)	11,713,901	0	11,713,901	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	CAPI TAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	NEW BLDG & FIXT (SQUARE FEET)					
	1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	402,636				1.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	652	74,505,879			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	43,727	7,003,835	-34,003,565	156,501,822	5.00
7.00 00700	OPERATION OF PLANT	98,660	2,172,987	0	9,779,626	259,597 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,026	150,568	0	967,579	1,026 8.00
9.00 00900	HOUSEKEEPING	4,583	1,564,033	0	3,030,379	4,583 9.00
10.00 01000	DIETARY	7,370	1,085,270	0	1,980,858	7,370 10.00
11.00 01100	CAFETERIA	7,145	740,028	0	1,757,627	7,145 11.00
13.00 01300	NURSING ADMINISTRATION	3,760	4,960,662	0	6,784,766	3,760 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,553	412,571	0	797,853	2,553 14.00
15.00 01500	PHARMACY	3,922	2,953,384	0	4,234,461	3,922 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,132	0	0	238,653	4,132 16.00
17.00 01700	SOCIAL SERVICE	395	1,009,290	0	1,338,282	395 17.00
23.00 02301	PARAMEDICAL ED PRGM	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	81,588	20,427,604	0	29,212,332	81,588 30.00
31.00 03100	INTENSIVE CARE UNIT	13,277	4,269,020	0	6,616,069	13,277 31.00
32.00 03200	CORONARY CARE UNIT	0	0	0	0	0 32.00
33.00 03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 34.00
41.00 04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00 04300	NURSERY	1,688	507,924	0	733,070	1,688 43.00
44.00 04400	SKILLED NURSING FACILITY	14,978	1,525,844	0	2,425,347	14,978 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	23,115	4,919,462	0	8,353,651	23,115 50.00
53.00 05300	ANESTHESIOLOGY	400	152,142	0	263,286	400 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	22,797	4,811,697	0	7,069,115	22,797 54.00
56.00 05600	RADIOISOTOPE	2,692	406,923	0	607,483	2,692 56.00
56.01 05601	ULTRASOUND	0	677,922	0	905,059	0 56.01
57.00 05700	CT SCAN	0	0	0	0	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	3,755	1,533,195	0	2,151,374	3,755 59.00
60.00 06000	LABORATORY	9,558	0	0	6,569,137	9,558 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,098	0	0	464,181	1,098 62.00
64.00 06400	INTRAVENOUS THERAPY	203	333,941	0	444,134	203 64.00
65.00 06500	RESPIRATORY THERAPY	2,147	1,554,764	0	2,151,269	2,147 65.00
66.00 06600	PHYSICAL THERAPY	5,556	94,654	0	2,997,630	5,556 66.00
67.00 06700	OCCUPATIONAL THERAPY	859	0	0	1,207,394	859 67.00
68.00 06800	SPEECH PATHOLOGY	203	304,680	0	409,778	203 68.00
69.00 06900	ELECTROCARDIOLOGY	872	1,124,277	0	1,524,092	872 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	898	94,231	0	168,333	898 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	12,580,375	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	10,207,295	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,032,456	0 73.00
74.00 07400	RENAL DIALYSIS	1,522	496,181	0	695,273	1,522 74.00
75.00 07500	ASC (NON-DISTINCT PART)	7,816	1,531,381	0	2,264,432	7,816 75.00
76.00 03560	PULMONARY FUNCTION TESTING	316	75,929	0	108,445	316 76.00
76.97 07697	CARDIAC REHABILITATION	3,005	366,724	0	578,962	3,005 76.97
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	7,599	2,284,239	0	3,313,667	7,599 90.00
91.00 09100	EMERGENCY	17,650	4,960,517	0	7,383,482	17,650 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
93.00 04950	SLEEP LAB	0	0	0	0	0 93.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
112.00 08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0 112.00
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0 114.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)		
	NEW BLDG & FIXT (SQUARE FEET)							
	1.00	4.00		5A	5.00	7.00		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		401,517	74,505,879	-34,003,565	156,347,205	258,478	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	623	0	0	141,029	623	190.00
190.01	19001	NONREIMBURSABLE HHA	496	0	0	13,588	496	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,041,025	17,801,021		34,003,565	11,904,475	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	27.421852	0.238921		0.217273	45.857521	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		17,990		1,506,267	2,803,742	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000241		0.009625	10.800364	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: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)		
		8.00	9.00	10.00	11.00	13.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT					7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	50,033				8.00	
9.00	00900	HOUSEKEEPING	0	253,988			9.00	
10.00	01000	DIETARY	0	7,370	50,033		10.00	
11.00	01100	CAFETERIA	0	7,145	0	61,789,158	11.00	
13.00	01300	NURSING ADMINISTRATION	0	3,760	0	4,960,662	41,919,937	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,553	0	412,571	0	14.00
15.00	01500	PHARMACY	0	3,922	0	2,953,384	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,132	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	395	0	1,009,290	986,670	17.00
23.00	02301	PARAMEDICAL ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	36,902	81,588	36,902	20,427,604	18,457,778	30.00
31.00	03100	INTENSIVE CARE UNIT	5,594	13,277	5,594	4,269,020	4,032,987	31.00
32.00	03200	CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,623	1,688	1,623	507,924	481,555	43.00
44.00	04400	SKILLED NURSING FACILITY	5,914	14,978	5,914	1,525,844	1,486,586	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	23,115	0	4,919,462	4,473,166	50.00
53.00	05300	ANESTHESIOLOGY	0	400	0	152,142	142,457	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	22,797	0	4,811,697	450,903	54.00
56.00	05600	RADIOISOTOPE	0	2,692	0	406,923	0	56.00
56.01	05601	ULTRASOUND	0	0	0	677,922	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,755	0	1,533,195	1,143,739	59.00
60.00	06000	LABORATORY	0	9,558	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,098	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	203	0	333,941	334,831	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,147	0	1,554,764	98,440	65.00
66.00	06600	PHYSICAL THERAPY	0	5,556	0	94,654	95,134	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	859	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	203	0	304,680	286,833	68.00
69.00	06900	ELECTROCARDIOLOGY	0	872	0	1,124,277	889,008	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	898	0	94,231	89,849	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,522	0	496,181	452,101	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	7,816	0	1,531,381	1,484,573	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	316	0	75,929	714	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,005	0	366,724	169,152	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	7,599	0	2,284,239	1,455,328	90.00
91.00	09100	EMERGENCY	0	17,650	0	4,960,517	4,908,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950	SLEEP LAB	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0	0	0	112.00
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,033	252,869	50,033	61,789,158	41,919,937	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	
		8.00	9.00	10.00	11.00	13.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	623	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	496	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,224,858	3,898,964	2,862,352	2,576,847	8,695,935
203.00		Unit cost multiplier (Wkst. B, Part I)	24.481003	15.350977	57.209282	0.041704	0.207442
204.00		Cost to be allocated (per Wkst. B, Part II)	48,565	204,716	339,702	295,952	237,007
205.00		Unit cost multiplier (Wkst. B, Part II)	0.970659	0.806007	6.789559	0.004790	0.005654
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	PARAMEDICAL ED PRGM (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400	1,115,374					14.00
15.00	01500	38,345	13,994,849				15.00
16.00	01600	0	0	885,862,659			16.00
17.00	01700	1,112	0	0	50,033		17.00
23.00	02301	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	245,123	205,165	122,210,225	36,902	0	30.00
31.00	03100	33,532	57,442	27,618,879	5,594	0	31.00
32.00	03200	0	0	0	0	0	32.00
33.00	03300	0	0	0	0	0	33.00
34.00	03400	0	0	0	0	0	34.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	2,198	859	2,223,920	1,623	0	43.00
44.00	04400	2,402	6,349	5,955,505	5,914	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	552,948	76,061	97,785,300	0	0	50.00
53.00	05300	2,781	71,951	23,049,032	0	0	53.00
54.00	05400	30,297	40,668	124,195,430	0	0	54.00
56.00	05600	207	629,478	9,386,484	0	0	56.00
56.01	05601	10,854	71	12,108,229	0	0	56.01
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	13,210	8,740	20,251,793	0	0	59.00
60.00	06000	0	0	66,558,765	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	4,498,446	0	0	62.00
64.00	06400	3,237	39,336	1,111,248	0	0	64.00
65.00	06500	26,663	303	11,820,479	0	0	65.00
66.00	06600	14,945	24	15,632,759	0	0	66.00
67.00	06700	0	0	6,719,457	0	0	67.00
68.00	06800	3,056	0	1,878,690	0	0	68.00
69.00	06900	15,249	2,893	21,019,315	0	0	69.00
70.00	07000	17,864	0	1,178,547	0	0	70.00
71.00	07100	0	0	20,785,969	0	0	71.00
72.00	07200	0	0	32,660,207	0	0	72.00
73.00	07300	0	12,472,891	121,493,664	0	0	73.00
74.00	07400	0	730	3,763,019	0	0	74.00
75.00	07500	13,992	96,839	10,752,645	0	0	75.00
76.00	03560	0	0	311,928	0	0	76.00
76.97	07697	9,467	0	1,342,942	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	22,765	31,074	17,840,404	0	0	90.00
91.00	09100	54,893	253,975	101,709,378	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
93.00	04950	0	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
100.00	10000	0	0	0	0	0	100.00
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
112.00	08600	0	0	0	0	0	112.00
113.00	11300	0	0	0	0	0	113.00
114.00	11400	0	0	0	0	0	114.00
118.00		1,115,140	13,994,849	885,862,659	50,033	0	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0250

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

Worksheet B-1

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	PARAMEDICAL ED PRGM (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	23.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	234	0	0	0	190.00
190.01	19001	NONREIMBURSABLE HHA	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	FUND RAISING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,144,676	5,557,075	543,419	1,901,142	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.026271	0.397080	0.000613	37.997761	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	230,633	317,452	214,177	39,183	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.206776	0.022683	0.000242	0.783143	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)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		50,058,682		0	50,058,682	30.00
31.00	03100 INTENSIVE CARE UNIT		10,624,560		0	10,624,560	31.00
32.00	03200 CORONARY CARE UNIT		0		0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		0	0	34.00
41.00	04100 SUBPROVIDER - IRF		0		0	0	41.00
42.00	04200 SUBPROVIDER		0		0	0	42.00
43.00	04300 NURSERY		1,314,956		0	1,314,956	43.00
44.00	04400 SKILLED NURSING FACILITY		4,957,577		0	4,957,577	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		13,374,212		0	13,374,212	50.00
53.00	05300 ANESTHESIOLOGY		426,424		0	426,424	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		10,418,374		0	10,418,374	54.00
56.00	05600 RADIOISOTOPE		1,177,135		0	1,177,135	56.00
56.01	05601 ULTRASOUND		1,148,565		0	1,148,565	56.01
57.00	05700 CT SCAN		0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION		3,179,288		0	3,179,288	59.00
60.00	06000 LABORATORY		8,622,265		0	8,622,265	60.00
60.01	06001 BLOOD LABORATORY		0		0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		635,000		0	635,000	62.00
64.00	06400 INTRAVENOUS THERAPY		656,065		0	656,065	64.00
65.00	06500 RESPIRATORY THERAPY	0	2,870,087		0	2,870,087	65.00
66.00	06600 PHYSICAL THERAPY	0	4,037,621		0	4,037,621	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,526,425		0	1,526,425	67.00
68.00	06800 SPEECH PATHOLOGY	0	587,732		0	587,732	68.00
69.00	06900 ELECTROCARDIOLOGY		2,169,599		0	2,169,599	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		301,495		0	301,495	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		15,326,493		0	15,326,493	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		12,445,086		0	12,445,086	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		22,108,543		0	22,108,543	73.00
74.00	07400 RENAL DIALYSIS		1,056,571		0	1,056,571	74.00
75.00	07500 ASC (NON-DISTINCT PART)		3,666,069		0	3,666,069	75.00
76.00	03560 PULMONARY FUNCTION TESTING		154,855		0	154,855	76.00
76.97	07697 CARDIAC REHABILITATION		949,609		0	949,609	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		0		0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	0	89.00
90.00	09000 CLINIC		4,942,556		0	4,942,556	90.00
91.00	09100 EMERGENCY		11,512,600		0	11,512,600	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		8,613,207		0	8,613,207	92.00
93.00	04950 SLEEP LAB		0		0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF		0		0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0		0	0	100.00
101.00	10100 HOME HEALTH AGENCY		0		0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION		0		0	0	109.00
110.00	11000 INTESTINAL ACQUISITION		0		0	0	110.00
111.00	11100 ISLET ACQUISITION		0		0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF		0		0	0	112.00
113.00	11300 INTEREST EXPENSE		0		0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF		0		0	0	114.00
200.00	Subtotal (see instructions)		198,861,651	0	0	198,861,651	200.00
201.00	Less Observation Beds		8,613,207	0	0	8,613,207	201.00
202.00	Total (see instructions)		190,248,444	0	0	190,248,444	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

			Title XVIII			Hospital		PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
	Inpatient	Outpatient	Total (col. 6 + col. 7)						
	6.00	7.00	8.00				9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	93,861,410		93,861,410				30.00
31.00	03100	INTENSIVE CARE UNIT	27,618,879		27,618,879				31.00
32.00	03200	CORONARY CARE UNIT	0		0				32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0				33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0				34.00
41.00	04100	SUBPROVIDER - I RF	0		0				41.00
42.00	04200	SUBPROVIDER	0		0				42.00
43.00	04300	NURSERY	2,223,920		2,223,920				43.00
44.00	04400	SKILLED NURSING FACILITY	5,955,505		5,955,505				44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	39,796,656	57,988,644	97,785,300	0.136771	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	7,496,684	15,552,348	23,049,032	0.018501	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,795,293	85,400,137	124,195,430	0.083887	0.000000		54.00
56.00	05600	RADIO SOTOPE	3,295,978	6,090,506	9,386,484	0.125407	0.000000		56.00
56.01	05601	ULTRASOUND	1,822,250	10,285,979	12,108,229	0.094858	0.000000		56.01
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	10,966,951	9,284,842	20,251,793	0.156988	0.000000		59.00
60.00	06000	LABORATORY	37,252,084	29,306,681	66,558,765	0.129544	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,338,067	1,160,379	4,498,446	0.141160	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	990,939	120,309	1,111,248	0.590386	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	10,245,451	1,575,028	11,820,479	0.242806	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	8,234,142	7,398,617	15,632,759	0.258279	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,208,957	2,510,500	6,719,457	0.227165	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,485,429	393,261	1,878,690	0.312841	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	9,147,710	11,871,605	21,019,315	0.103219	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	618,095	560,452	1,178,547	0.255819	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,157,361	7,628,608	20,785,969	0.737348	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,534,286	16,125,921	32,660,207	0.381047	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,610,175	55,883,489	121,493,664	0.181973	0.000000		73.00
74.00	07400	RENAL DIALYSIS	3,289,925	473,094	3,763,019	0.280777	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	766,565	9,986,080	10,752,645	0.340946	0.000000		75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	311,928	311,928	0.496445	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	31,900	1,311,042	1,342,942	0.707111	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0				89.00
90.00	09000	CLINIC	141,803	17,698,601	17,840,404	0.277043	0.000000		90.00
91.00	09100	EMERGENCY	26,373,510	75,335,868	101,709,378	0.113191	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,165,850	15,182,965	28,348,815	0.303830	0.000000		92.00
93.00	04950	SLEEP LAB	0	0	0	0.000000	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0				99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0				100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0	0	0				109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0				110.00
111.00	11100	ISLET ACQUISITION	0	0	0				111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0				112.00
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	446,425,775	439,436,884	885,862,659				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	446,425,775	439,436,884	885,862,659				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/23/2018 2:00 pm
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
32.00	03200 CORONARY CARE UNIT			32.00
33.00	03300 BURN INTENSIVE CARE UNIT			33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.136771		50.00
53.00	05300 ANESTHESIOLOGY	0.018501		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.083887		54.00
56.00	05600 RADIOISOTOPE	0.125407		56.00
56.01	05601 ULTRASOUND	0.094858		56.01
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.156988		59.00
60.00	06000 LABORATORY	0.129544		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.141160		62.00
64.00	06400 INTRAVENOUS THERAPY	0.590386		64.00
65.00	06500 RESPIRATORY THERAPY	0.242806		65.00
66.00	06600 PHYSICAL THERAPY	0.258279		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.227165		67.00
68.00	06800 SPEECH PATHOLOGY	0.312841		68.00
69.00	06900 ELECTROCARDIOLOGY	0.103219		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.255819		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737348		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.381047		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181973		73.00
74.00	07400 RENAL DIALYSIS	0.280777		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.340946		75.00
76.00	03560 PULMONARY FUNCTION TESTING	0.496445		76.00
76.97	07697 CARDIAC REHABILITATION	0.707111		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.277043		90.00
91.00	09100 EMERGENCY	0.113191		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.303830		92.00
93.00	04950 SLEEP LAB	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF			112.00
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	50,058,682		50,058,682	0	50,058,682	30.00
31.00	03100 INTENSIVE CARE UNIT	10,624,560		10,624,560	0	10,624,560	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	1,314,956		1,314,956	0	1,314,956	43.00
44.00	04400 SKILLED NURSING FACILITY	4,957,577		4,957,577	0	4,957,577	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	13,374,212		13,374,212	0	13,374,212	50.00
53.00	05300 ANESTHESIOLOGY	426,424		426,424	0	426,424	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	10,418,374		10,418,374	0	10,418,374	54.00
56.00	05600 RADIOISOTOPE	1,177,135		1,177,135	0	1,177,135	56.00
56.01	05601 ULTRASOUND	1,148,565		1,148,565	0	1,148,565	56.01
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	3,179,288		3,179,288	0	3,179,288	59.00
60.00	06000 LABORATORY	8,622,265		8,622,265	0	8,622,265	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	635,000		635,000	0	635,000	62.00
64.00	06400 INTRAVENOUS THERAPY	656,065		656,065	0	656,065	64.00
65.00	06500 RESPIRATORY THERAPY	2,870,087	0	2,870,087	0	2,870,087	65.00
66.00	06600 PHYSICAL THERAPY	4,037,621	0	4,037,621	0	4,037,621	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,526,425	0	1,526,425	0	1,526,425	67.00
68.00	06800 SPEECH PATHOLOGY	587,732	0	587,732	0	587,732	68.00
69.00	06900 ELECTROCARDIOLOGY	2,169,599		2,169,599	0	2,169,599	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	301,495		301,495	0	301,495	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15,326,493		15,326,493	0	15,326,493	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12,445,086		12,445,086	0	12,445,086	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,108,543		22,108,543	0	22,108,543	73.00
74.00	07400 RENAL DIALYSIS	1,056,571		1,056,571	0	1,056,571	74.00
75.00	07500 ASC (NON-DISTINCT PART)	3,666,069		3,666,069	0	3,666,069	75.00
76.00	03560 PULMONARY FUNCTION TESTING	154,855		154,855	0	154,855	76.00
76.97	07697 CARDIAC REHABILITATION	949,609		949,609	0	949,609	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	4,942,556		4,942,556	0	4,942,556	90.00
91.00	09100 EMERGENCY	11,512,600		11,512,600	0	11,512,600	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8,613,207		8,613,207	0	8,613,207	92.00
93.00	04950 SLEEP LAB	0		0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
112.00	08600 OTHER ORGAN ACQUISITION (SPECIF	0		0	0	0	112.00
113.00	11300 INTEREST EXPENSE	0		0	0	0	113.00
114.00	11400 UTILIZATION REVIEW-SNF	0		0	0	0	114.00
200.00	Subtotal (see instructions)	198,861,651	0	198,861,651	0	198,861,651	200.00
201.00	Less Observation Beds	8,613,207		8,613,207	0	8,613,207	201.00
202.00	Total (see instructions)	190,248,444	0	190,248,444	0	190,248,444	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0250

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

Worksheet C
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	93,861,410		93,861,410		30.00
31.00	03100	INTENSIVE CARE UNIT	27,618,879		27,618,879		31.00
32.00	03200	CORONARY CARE UNIT	0		0		32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0		34.00
41.00	04100	SUBPROVIDER - I RF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	2,223,920		2,223,920		43.00
44.00	04400	SKILLED NURSING FACILITY	5,955,505		5,955,505		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,796,656	57,988,644	97,785,300	0.136771	50.00
53.00	05300	ANESTHESIOLOGY	7,496,684	15,552,348	23,049,032	0.018501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,795,293	85,400,137	124,195,430	0.083887	54.00
56.00	05600	RADIO SOTOPE	3,295,978	6,090,506	9,386,484	0.125407	56.00
56.01	05601	ULTRASOUND	1,822,250	10,285,979	12,108,229	0.094858	56.01
57.00	05700	CT SCAN	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,966,951	9,284,842	20,251,793	0.156988	59.00
60.00	06000	LABORATORY	37,252,084	29,306,681	66,558,765	0.129544	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,338,067	1,160,379	4,498,446	0.141160	62.00
64.00	06400	INTRAVENOUS THERAPY	990,939	120,309	1,111,248	0.590386	64.00
65.00	06500	RESPIRATORY THERAPY	10,245,451	1,575,028	11,820,479	0.242806	65.00
66.00	06600	PHYSICAL THERAPY	8,234,142	7,398,617	15,632,759	0.258279	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,208,957	2,510,500	6,719,457	0.227165	67.00
68.00	06800	SPEECH PATHOLOGY	1,485,429	393,261	1,878,690	0.312841	68.00
69.00	06900	ELECTROCARDIOLOGY	9,147,710	11,871,605	21,019,315	0.103219	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	618,095	560,452	1,178,547	0.255819	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,157,361	7,628,608	20,785,969	0.737348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,534,286	16,125,921	32,660,207	0.381047	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,610,175	55,883,489	121,493,664	0.181973	73.00
74.00	07400	RENAL DIALYSIS	3,289,925	473,094	3,763,019	0.280777	74.00
75.00	07500	ASC (NON-DISTINCT PART)	766,565	9,986,080	10,752,645	0.340946	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	311,928	311,928	0.496445	76.00
76.97	07697	CARDIAC REHABILITATION	31,900	1,311,042	1,342,942	0.707111	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	141,803	17,698,601	17,840,404	0.277043	90.00
91.00	09100	EMERGENCY	26,373,510	75,335,868	101,709,378	0.113191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	13,165,850	15,182,965	28,348,815	0.303830	92.00
93.00	04950	SLEEP LAB	0	0	0	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF	0	0	0		112.00
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	446,425,775	439,436,884	885,862,659		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	446,425,775	439,436,884	885,862,659		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/23/2018 2:00 pm
Cost Center Description			PPS Inpatient Ratio 11.00	Title XIX	Hospital
					Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
32.00	03200	CORONARY CARE UNIT			32.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	05601	ULTRASOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04950	SLEEP LAB	0.000000		93.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
100.00	10000	I&R SERVICES-NOT APPRVD PRGM			100.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
112.00	08600	OTHER ORGAN ACQUISITION (SPECIF			112.00
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0250

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

Worksheet D
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		Title XVIII			Hospital		PPS
		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	4,084,045	0	4,084,045	44,571	91.63	30.00
31.00	INTENSIVE CARE UNIT	688,851		688,851	5,594	123.14	31.00
32.00	CORONARY CARE UNIT	0		0	0	0.00	32.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	93,090		93,090	1,623	57.36	43.00
44.00	SKILLED NURSING FACILITY	676,597		676,597	5,914	114.41	44.00
200.00	Total (lines 30 through 199)	5,542,583		5,542,583	57,702		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	13,406	1,228,392				
31.00	INTENSIVE CARE UNIT	2,202	271,154				
32.00	CORONARY CARE UNIT	0	0				
33.00	BURN INTENSIVE CARE UNIT	0	0				
34.00	SURGICAL INTENSIVE CARE UNIT	0	0				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	2,673	305,818				
200.00	Total (lines 30 through 199)	18,281	1,805,364				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0250

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

Worksheet D
Part II
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,178,957	97,785,300	0.012057	12,689,056	152,992	50.00
53.00	05300	ANESTHESIOLOGY	27,501	23,049,032	0.001193	2,198,406	2,623	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,021,564	124,195,430	0.008225	13,685,949	112,567	54.00
56.00	05600	RADIOISOTOPE	129,552	9,386,484	0.013802	1,097,950	15,154	56.00
56.01	05601	ULTRASOUND	21,297	12,108,229	0.001759	510,895	899	56.01
57.00	05700	CT SCAN	0	0	0.000000	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	191,563	20,251,793	0.009459	3,896,926	36,861	59.00
60.00	06000	LABORATORY	452,367	66,558,765	0.006797	12,476,443	84,802	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	48,410	4,498,446	0.010761	1,211,089	13,033	62.00
64.00	06400	INTRAVENOUS THERAPY	17,601	1,111,248	0.015839	345,311	5,469	64.00
65.00	06500	RESPIRATORY THERAPY	153,392	11,820,479	0.012977	4,294,411	55,729	65.00
66.00	06600	PHYSICAL THERAPY	253,581	15,632,759	0.016221	2,669,552	43,303	66.00
67.00	06700	OCCUPATIONAL THERAPY	46,772	6,719,457	0.006961	831,721	5,790	67.00
68.00	06800	SPEECH PATHOLOGY	16,108	1,878,690	0.008574	659,954	5,658	68.00
69.00	06900	ELECTROCARDIOLOGY	67,690	21,019,315	0.003220	3,355,465	10,805	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	41,629	1,178,547	0.035322	241,582	8,533	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	126,116	20,785,969	0.006067	4,638,273	28,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	106,149	32,660,207	0.003250	5,533,122	17,983	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	447,392	121,493,664	0.003682	22,613,863	83,264	73.00
74.00	07400	RENAL DIALYSIS	72,074	3,763,019	0.019153	1,674,952	32,080	74.00
75.00	07500	ASC (NON-DISTINCT PART)	350,630	10,752,645	0.032609	280,656	9,152	75.00
76.00	03560	PULMONARY FUNCTION TESTING	13,838	311,928	0.044363	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	127,937	1,342,942	0.095266	7,830	746	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	357,920	17,840,404	0.020062	34,697	696	90.00
91.00	09100	EMERGENCY	856,069	101,709,378	0.008417	9,606,751	80,860	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	702,708	28,348,815	0.024788	4,709,300	116,734	92.00
93.00	04950	SLEEP LAB	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	6,828,817	756,202,945		109,264,154	923,873	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 5/23/2018 2:00 pm
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Cost Center Description		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
32.00	03200	CORONARY CARE UNIT	0	0	0	0	32.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	44,571	0.00	13,406	
31.00	03100	INTENSIVE CARE UNIT	0	0	5,594	0.00	2,202	
32.00	03200	CORONARY CARE UNIT	0	0	0	0.00	0	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0.00	0	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0.00	0	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	
43.00	04300	NURSERY	0	0	1,623	0.00	0	
44.00	04400	SKILLED NURSING FACILITY	0	0	5,914	0.00	2,673	
200.00		Total (lines 30 through 199)	0	0	57,702	0.00	18,281	
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
		9.00						
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
32.00	03200	CORONARY CARE UNIT	0					32.00
33.00	03300	BURN INTENSIVE CARE UNIT	0					33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0					34.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
42.00	04200	SUBPROVIDER	0					42.00
43.00	04300	NURSERY	0					43.00
44.00	04400	SKILLED NURSING FACILITY	0					44.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 2:00 pm
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Cost Center Description	Title XVIII					Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00	
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00	
56.01 05601 ULTRASOUND	0	0	0	0	0	0	56.01	
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	0	62.00	
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00	
76.00 03560 PULMONARY FUNCTION TESTING	0	0	0	0	0	0	76.00	
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97	
OUTPATIENT SERVICE COST CENTERS								
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00	
90.00 09000 CLINIC	0	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00	
93.00 04950 SLEEP LAB	0	0	0	0	0	0	93.00	
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 2:00 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	97,785,300	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	23,049,032	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	124,195,430	0.000000	54.00
56.00	05600	RADIO SOTOPE	0	0	0	9,386,484	0.000000	56.00
56.01	05601	ULTRASOUND	0	0	0	12,108,229	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20,251,793	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	66,558,765	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	4,498,446	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,111,248	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,820,479	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,632,759	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,719,457	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,878,690	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	21,019,315	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,178,547	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,785,969	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	32,660,207	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	121,493,664	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,763,019	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	10,752,645	0.000000	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	0	0	311,928	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,342,942	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	17,840,404	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	101,709,378	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	28,348,815	0.000000	92.00
93.00	04950	SLEEP LAB	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	756,202,945		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0250

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

Worksheet D
Part IV
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PPS
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	12,689,056	0	11,044,432	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	2,198,406	0	2,866,781	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	13,685,949	0	16,412,039	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	1,097,950	0	1,814,169	0	56.00
56.01	05601 ULTRASOUND	0.000000	510,895	0	1,017,395	0	56.01
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	3,896,926	0	2,952,661	0	59.00
60.00	06000 LABORATORY	0.000000	12,476,443	0	4,513,321	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	1,211,089	0	241,769	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	345,311	0	41,200	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	4,294,411	0	406,528	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	2,669,552	0	130,963	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	831,721	0	57,393	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	659,954	0	29,130	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,355,465	0	2,836,873	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	241,582	0	129,995	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,638,273	0	1,802,096	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	5,533,122	0	4,789,911	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	22,613,863	0	13,027,750	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	1,674,952	0	249,283	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	280,656	0	1,961,914	0	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0.000000	0	0	125,446	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	7,830	0	354,932	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	34,697	0	4,640,157	0	90.00
91.00	09100 EMERGENCY	0.000000	9,606,751	0	10,388,399	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	4,709,300	0	3,915,980	0	92.00
93.00	04950 SLEEP LAB	0.000000	0	0	0	0	93.00
200.00	Total (lines 50 through 199)		109,264,154	0	85,750,517	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 2:00 pm
Title XVIII			Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.136771	11,044,432	0	0	1,510,558	50.00
53.00	05300	ANESTHESIOLOGY	0.018501	2,866,781	0	0	53,038	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083887	16,412,039	0	0	1,376,757	54.00
56.00	05600	RADIOISOTOPE	0.125407	1,814,169	0	0	227,509	56.00
56.01	05601	ULTRASOUND	0.094858	1,017,395	0	0	96,508	56.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.156988	2,952,661	0	0	463,532	59.00
60.00	06000	LABORATORY	0.129544	4,513,321	0	1,250	584,674	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.141160	241,769	0	0	34,128	62.00
64.00	06400	INTRAVENOUS THERAPY	0.590386	41,200	0	0	24,324	64.00
65.00	06500	RESPIRATORY THERAPY	0.242806	406,528	0	0	98,707	65.00
66.00	06600	PHYSICAL THERAPY	0.258279	130,963	0	0	33,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227165	57,393	0	0	13,038	67.00
68.00	06800	SPEECH PATHOLOGY	0.312841	29,130	0	0	9,113	68.00
69.00	06900	ELECTROCARDIOLOGY	0.103219	2,836,873	0	0	292,819	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.255819	129,995	0	0	33,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737348	1,802,096	0	0	1,328,772	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.381047	4,789,911	0	127,190	1,825,181	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181973	13,027,750	0	52,242	2,370,699	73.00
74.00	07400	RENAL DIALYSIS	0.280777	249,283	0	9,085	69,993	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.340946	1,961,914	0	0	668,907	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.496445	125,446	0	0	62,277	76.00
76.97	07697	CARDIAC REHABILITATION	0.707111	354,932	0	0	250,976	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.277043	4,640,157	0	0	1,285,523	90.00
91.00	09100	EMERGENCY	0.113191	10,388,399	0	92	1,175,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303830	3,915,980	0	0	1,189,792	92.00
93.00	04950	SLEEP LAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		85,750,517	0	189,859	15,079,778	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		85,750,517	0	189,859	15,079,778	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 2:00 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs		50.00
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
56.01 05601 ULTRASOUND	0	0	56.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	162	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	48,465	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	9,507	73.00
74.00 07400 RENAL DIALYSIS	0	2,551	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03560 PULMONARY FUNCTION TESTING	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	10	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
93.00 04950 SLEEP LAB	0	0	93.00
200.00 Subtotal (see instructions)	0	60,695	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	60,695	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 2:00 pm
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05601 ULTRASOUND	0	0	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04950 SLEEP LAB	0	0	0	0	0	93.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 2:00 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	97,785,300	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	23,049,032	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	124,195,430	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	9,386,484	0.000000	56.00
56.01	05601	ULTRASOUND	0	0	0	12,108,229	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	20,251,793	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	66,558,765	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	4,498,446	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,111,248	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,820,479	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,632,759	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,719,457	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,878,690	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	21,019,315	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,178,547	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	20,785,969	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	32,660,207	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	121,493,664	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,763,019	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	10,752,645	0.000000	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0	0	0	311,928	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,342,942	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	17,840,404	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	101,709,378	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	28,348,815	0.000000	92.00
93.00	04950	SLEEP LAB	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	0	756,202,945		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/23/2018 2:00 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	18,332	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	2,853	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	81,555	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	8,103	0	0	0	56.00
56.01	05601 ULTRASOUND	0.000000	6,983	0	0	0	56.01
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	282,037	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	5,629	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	662	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	179,404	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	836,541	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,025,522	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	33,739	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	12,795	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	2,560	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	286,247	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	529,393	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	623	0	0	0	75.00
76.00	03560 PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	295	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000 CLINIC	0.000000	13,879	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04950 SLEEP LAB	0.000000	0	0	0	0	93.00
200.00	Total (lines 50 through 199)		3,327,152	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0250

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

Worksheet D
Part V
Date/Time Prepared:
5/23/2018 2:00 pm

		Title XIX		Hospital		Cost		
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	0.136771	0	0	417,817	0	50.00
53.00	05300	ANESTHESIOLOGY	0.018501	0	0	104,609	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083887	0	0	2,402,528	0	54.00
56.00	05600	RADIOISOTOPE	0.125407	0	0	98,567	0	56.00
56.01	05601	ULTRASOUND	0.094858	0	0	634,155	0	56.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.156988	0	0	68,078	0	59.00
60.00	06000	LABORATORY	0.129544	0	0	1,386,850	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.141160	0	0	57,361	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.590386	0	0	3,335	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.242806	0	0	45,409	0	65.00
66.00	06600	PHYSICAL THERAPY	0.258279	0	0	132,059	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227165	0	0	57,586	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.312841	0	0	9,250	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.103219	0	0	320,201	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.255819	0	0	18,910	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737348	0	0	56,933	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.381047	0	0	25,240	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181973	0	0	1,402,033	0	73.00
74.00	07400	RENAL DIALYSIS	0.280777	0	0	11,780	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.340946	0	0	59,039	0	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.496445	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.707111	0	0	6,315	0	76.97
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.277043	0	0	233,615	0	90.00
91.00	09100	EMERGENCY	0.113191	0	0	5,754,214	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303830	0	0	568,635	0	92.00
93.00	04950	SLEEP LAB	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	0	13,874,519	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	13,874,519	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/23/2018 2:00 pm
	Title XIX	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	57,145		50.00
53.00 05300 ANESTHESIOLOGY	0	1,935		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	201,541		54.00
56.00 05600 RADIOISOTOPE	0	12,361		56.00
56.01 05601 ULTRASOUND	0	60,155		56.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	10,687		59.00
60.00 06000 LABORATORY	0	179,658		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	8,097		62.00
64.00 06400 INTRAVENOUS THERAPY	0	1,969		64.00
65.00 06500 RESPIRATORY THERAPY	0	11,026		65.00
66.00 06600 PHYSICAL THERAPY	0	34,108		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	13,082		67.00
68.00 06800 SPEECH PATHOLOGY	0	2,894		68.00
69.00 06900 ELECTROCARDIOLOGY	0	33,051		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	4,838		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41,979		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	9,618		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	255,132		73.00
74.00 07400 RENAL DIALYSIS	0	3,308		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	20,129		75.00
76.00 03560 PULMONARY FUNCTION TESTING	0	0		76.00
76.97 07697 CARDIAC REHABILITATION	0	4,465		76.97
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	64,721		90.00
91.00 09100 EMERGENCY	0	651,325		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	172,768		92.00
93.00 04950 SLEEP LAB	0	0		93.00
200.00	Subtotal (see instructions)	0	1,855,992	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	1,855,992	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/23/2018 2:00 pm
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)		44,571	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		44,571	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)		36,902	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)		13,406	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)		50,058,682	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)		50,058,682	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)		50,058,682	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)		1,123.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,056,547	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)		15,056,547	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
Title XVIII		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	10,624,560	5,594	1,899.28	2,202	4,182,215	43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					20,991,848	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					40,230,610	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)					1,499,546	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					923,873	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,423,419	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,807,191	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)					7,669	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,123.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					8,613,207	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,084,045	50,058,682	0.081585	8,613,207	702,708	90.00
91.00	Nursing School cost	0	50,058,682	0.000000	8,613,207	0	91.00
92.00	Allied health cost	0	50,058,682	0.000000	8,613,207	0	92.00
93.00	All other Medical Education	0	50,058,682	0.000000	8,613,207	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Skilled Nursing Facility	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)		5,914	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,914	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)		5,914	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)		2,673	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)		4,957,577	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)		4,957,577	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)		4,957,577	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0250 Component CCN: 14-5599		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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						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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					4,957,577	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					838.28	71.00
72.00	Program routine service cost (line 9 x line 71)					2,240,722	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					2,240,722	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					2,240,722	83.00
84.00	Program inpatient ancillary services (see instructions)					865,581	84.00
85.00	Utilization review - physician compensation (see instructions)					22,500	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					3,128,803	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: 14-0250 Component CCN: 14-5599		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/23/2018 2:00 pm	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

Cost Center Description	Percent of Assigned Time	Expense Allocation	Total Inpatient Day All Patients	Average Cost Per Day	Health Care Program Inpatient Days Title V																																																																																																																															
	1.00	2.00	3.00	4.00	5.00																																																																																																																															
PART I - NOT IN APPROVED TEACHING PROGRAM																																																																																																																																				
Hospital Inpatient Routine Services:																																																																																																																																				
1.00 Total cost of services rendered	0.00	0				1.00																																																																																																																														
2.00 ADULTS & PEDIATRICS	0.00	0	44,571	0.00	0	2.00																																																																																																																														
3.00 INTENSIVE CARE UNIT	0.00	0	5,594	0.00	0	3.00																																																																																																																														
4.00 CORONARY CARE UNIT	0.00	0	0	0.00	0	4.00																																																																																																																														
5.00 BURN INTENSIVE CARE UNIT	0.00	0	0	0.00	0	5.00																																																																																																																														
6.00 SURGICAL INTENSIVE CARE UNIT	0.00	0	0	0.00	0	6.00																																																																																																																														
7.00 OTHER SPECIAL CARE (SPECIFY)						7.00																																																																																																																														
8.00 NURSERY	0.00	0	1,623	0.00	0	8.00																																																																																																																														
9.00 Subtotal (sum of lines 2 through 8)	0.00	0				9.00																																																																																																																														
10.00 SUBPROVIDER - IPF						10.00																																																																																																																														
11.00 SUBPROVIDER - IRF	0.00	0	0	0.00	0	11.00																																																																																																																														
12.00 SUBPROVIDER	0.00	0	0	0.00	0	12.00																																																																																																																														
13.00 SKILLED NURSING FACILITY	0.00	0	5,914	0.00	0	13.00																																																																																																																														
14.00 NURSING FACILITY						14.00																																																																																																																														
15.00 OTHER LONG TERM CARE						15.00																																																																																																																														
16.00 HOME HEALTH AGENCY	0.00	0				16.00																																																																																																																														
17.00 CMHC						17.00																																																																																																																														
17.10 CORF	0.00	0				17.10																																																																																																																														
18.00 AMBULATORY SURGICAL CENTER (D.P.)						18.00																																																																																																																														
19.00 HOSPICE						19.00																																																																																																																														
20.00 Subtotal (sum of lines 9 through 19)	0.00	0				20.00																																																																																																																														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th></th> <th></th> <th>Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)</th> <th>Ratio of Cost to Charges (col. 2 ÷ col. 3)</th> <th>Titles V and XIX Outpatient and Title XVIII Part B Charges Title V</th> <th></th> </tr> <tr> <th></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> <th></th> </tr> </thead> <tbody> <tr> <td colspan="7">Hospital Outpatient Services:</td> </tr> <tr> <td>21.00 RURAL HEALTH CLINIC</td> <td>0.00</td> <td>0</td> <td>0</td> <td>0.000000</td> <td>0</td> <td>21.00</td> </tr> <tr> <td>22.00 FEDERALLY QUALIFIED HEALTH CENTER</td> <td>0.00</td> <td>0</td> <td>0</td> <td>0.000000</td> <td>0</td> <td>22.00</td> </tr> <tr> <td>23.00 CLINIC</td> <td>0.00</td> <td>0</td> <td>17,840,404</td> <td>0.000000</td> <td>0</td> <td>23.00</td> </tr> <tr> <td>24.00 EMERGENCY</td> <td>0.00</td> <td>0</td> <td>101,709,378</td> <td>0.000000</td> <td>0</td> <td>24.00</td> </tr> <tr> <td>25.00 OBSERVATION BEDS (NON-DISTINCT PART)</td> <td>0.00</td> <td>0</td> <td>28,348,815</td> <td>0.000000</td> <td>0</td> <td>25.00</td> </tr> <tr> <td>26.00 SLEEP LAB</td> <td>0.00</td> <td>0</td> <td>0</td> <td>0.000000</td> <td>0</td> <td>26.00</td> </tr> <tr> <td>27.00 Subtotal (sum of lines 21 through 26)</td> <td>0.00</td> <td>0</td> <td></td> <td></td> <td></td> <td>27.00</td> </tr> <tr> <td>28.00 Total (sum of lines 20 and 27)</td> <td>0.00</td> <td>0</td> <td></td> <td></td> <td></td> <td>28.00</td> </tr> </tbody> </table>							Cost Center Description			Total Charges (from Worksheet C, Part I, column 8, lines 88 through 93)	Ratio of Cost to Charges (col. 2 ÷ col. 3)	Titles V and XIX Outpatient and Title XVIII Part B Charges Title V			1.00	2.00	3.00	4.00	5.00		Hospital Outpatient Services:							21.00 RURAL HEALTH CLINIC	0.00	0	0	0.000000	0	21.00	22.00 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0	0	0.000000	0	22.00	23.00 CLINIC	0.00	0	17,840,404	0.000000	0	23.00	24.00 EMERGENCY	0.00	0	101,709,378	0.000000	0	24.00	25.00 OBSERVATION BEDS (NON-DISTINCT PART)	0.00	0	28,348,815	0.000000	0	25.00	26.00 SLEEP LAB	0.00	0	0	0.000000	0	26.00	27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00	28.00 Total (sum of lines 20 and 27)	0.00	0				28.00																																																	
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27.00 Subtotal (sum of lines 21 through 26)	0.00	0				27.00																																																																																																																														
28.00 Total (sum of lines 20 and 27)	0.00	0				28.00																																																																																																																														
<table border="1"> <thead> <tr> <th>Cost Center Description</th> <th>Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22</th> <th>Swing bed Amount</th> <th>Net cost (column 1 plus column 2)</th> <th>Total Inpatient Days - All Patients</th> <th>Average Cost Per Day (col. 3 ÷ col. 4)</th> <th></th> </tr> <tr> <th></th> <th>1.00</th> <th>2.00</th> <th>3.00</th> <th>4.00</th> <th>5.00</th> <th></th> </tr> </thead> <tbody> <tr> <td colspan="7">PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)</td> </tr> <tr> <td colspan="7">Hospital Inpatient Routine Services:</td> </tr> <tr> <td>29.00 ADULTS & PEDIATRICS</td> <td>0</td> <td>0</td> <td>0</td> <td>44,571</td> <td>0.00</td> <td>29.00</td> </tr> <tr> <td>30.00 Swing Bed - SNF</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>30.00</td> </tr> <tr> <td>31.00 Swing Bed - NF</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>31.00</td> </tr> <tr> <td>32.00 INTENSIVE CARE UNIT</td> <td>0</td> <td>0</td> <td>0</td> <td>5,594</td> <td>0.00</td> <td>32.00</td> </tr> <tr> <td>33.00 CORONARY CARE UNIT</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>33.00</td> </tr> <tr> <td>34.00 BURN INTENSIVE CARE UNIT</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>34.00</td> </tr> <tr> <td>35.00 SURGICAL INTENSIVE CARE UNIT</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>35.00</td> </tr> <tr> <td>36.00 OTHER SPECIAL CARE (SPECIFY)</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>36.00</td> </tr> <tr> <td>37.00 Subtotal (sum of lines 29, and 32 through 36)</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>37.00</td> </tr> <tr> <td>38.00 SUBPROVIDER - IPF</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>38.00</td> </tr> <tr> <td>39.00 SUBPROVIDER - IRF</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>39.00</td> </tr> <tr> <td>40.00 SUBPROVIDER</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>40.00</td> </tr> <tr> <td>41.00 SKILLED NURSING FACILITY</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>41.00</td> </tr> <tr> <td>42.00 Total (sum of lines 37 through 41)</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0.00</td> <td>42.00</td> </tr> </tbody> </table>							Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)			1.00	2.00	3.00	4.00	5.00		PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)							Hospital Inpatient Routine Services:							29.00 ADULTS & PEDIATRICS	0	0	0	44,571	0.00	29.00	30.00 Swing Bed - SNF		0	0	0	0.00	30.00	31.00 Swing Bed - NF		0	0	0	0.00	31.00	32.00 INTENSIVE CARE UNIT	0	0	0	5,594	0.00	32.00	33.00 CORONARY CARE UNIT	0	0	0	0	0.00	33.00	34.00 BURN INTENSIVE CARE UNIT	0	0	0	0	0.00	34.00	35.00 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0.00	35.00	36.00 OTHER SPECIAL CARE (SPECIFY)						36.00	37.00 Subtotal (sum of lines 29, and 32 through 36)	0	0	0	0	0.00	37.00	38.00 SUBPROVIDER - IPF						38.00	39.00 SUBPROVIDER - IRF	0	0	0	0	0.00	39.00	40.00 SUBPROVIDER	0	0	0	0	0.00	40.00	41.00 SKILLED NURSING FACILITY	0	0	0	0	0.00	41.00	42.00 Total (sum of lines 37 through 41)	0	0	0	0	0.00	42.00
Cost Center Description	Expenses Allocated To cost centers on Worksheet B, Part I columns 21 and 22	Swing bed Amount	Net cost (column 1 plus column 2)	Total Inpatient Days - All Patients	Average Cost Per Day (col. 3 ÷ col. 4)																																																																																																																															
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39.00 SUBPROVIDER - IRF	0	0	0	0	0.00	39.00																																																																																																																														
40.00 SUBPROVIDER	0	0	0	0	0.00	40.00																																																																																																																														
41.00 SKILLED NURSING FACILITY	0	0	0	0	0.00	41.00																																																																																																																														
42.00 Total (sum of lines 37 through 41)	0	0	0	0	0.00	42.00																																																																																																																														

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-0250

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

Worksheet D-2

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	Not In Approved Teaching Program		In Approved Teaching Program	
	(from Part I:)	Amount	(from Part II, col. 7, -)	
	1.00	2.00	3.00	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
Hospital				
43.00 Inpatient	col. 9, line 9.00		0 line 37.00	43.00
44.00 Outpatient	col. 9, line 27.00		0	44.00
45.00 Total Hospital (sum of lines 43 and 44)			0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF	col. 9, line 11.00		0 col. 9, line 39.00	47.00
48.00 SUBPROVIDER	col. 9, line 12.00		0 col. 9, line 40.00	48.00
49.00 SKILLED NURSING FACILITY	col. 9, line 13.00		0 col. 9, line 41.00	49.00

Cost Center Description	Health Care Program Inpatient Days		Title V (col. 4 x col. 5)	Title XVIII (col. 4 x col. 6)	Title XIX (col. 4 x col. 7)	
	Title XVIII, Part B Only Less Part A Coverage but no Part B Coverage	Title XIX				
	6.00	7.00				
PART I - NOT IN APPROVED TEACHING PROGRAM						
1.00	Total cost of services rendered					1.00
Hospital Inpatient Routine Services:						
2.00	ADULTS & PEDIATRICS	13,406	0	0	0	2.00
3.00	INTENSIVE CARE UNIT	2,202	0	0	0	3.00
4.00	CORONARY CARE UNIT	0	0	0	0	4.00
5.00	BURN INTENSIVE CARE UNIT	0	0	0	0	5.00
6.00	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	6.00
7.00	OTHER SPECIAL CARE (SPECIFY)					7.00
8.00	NURSERY		0	0	0	8.00
9.00	Subtotal (sum of lines 2 through 8)			0	0	9.00
10.00	SUBPROVIDER - IPF			0	0	10.00
11.00	SUBPROVIDER - IRF	0	0	0	0	11.00
12.00	SUBPROVIDER	0	0	0	0	12.00
13.00	SKILLED NURSING FACILITY	2,673	0	0	0	13.00
14.00	NURSING FACILITY					14.00
15.00	OTHER LONG TERM CARE					15.00
16.00	HOME HEALTH AGENCY					16.00
17.00	CMHC					17.00
17.10	CORF					17.10
18.00	AMBULATORY SURGICAL CENTER (D.P.)					18.00
19.00	HOSPICE					19.00
20.00	Subtotal (sum of lines 9 through 19)					20.00
Cost Center Description		Titles V and XIX Outpatient and Title XVIII Part B Charges		Titles V and XIX Outpatient and Title XVIII Part B Cost		
		Title XVIII Part B	Title XIX	Title V	Title XVIII Part B	Title XIX
		6.00	7.00	8.00	9.00	10.00
Hospital Outpatient Services:						
21.00	RURAL HEALTH CLINIC	0	0	0	0	21.00
22.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	22.00
23.00	CLINIC	4,674,854	233,615	0	0	23.00
24.00	EMERGENCY	19,995,242	6,900,075	0	0	24.00
25.00	OBSERVATION BEDS (NON-DISTINCT PART)	8,625,280	955,860	0	0	25.00
26.00	SLEEP LAB	0	0	0	0	26.00
27.00	Subtotal (sum of lines 21 through 26)			0	0	27.00
28.00	Total (sum of lines 20 and 27)					28.00
Cost Center Description		Title XVIII Part B Inpatient Days	Expenses Applicable to Title XVIII (col. 5 x col. 6)	PSA Adj. Interns & Residents		
		6.00	7.00	11.00		
PART II - IN AN APPROVED TEACHING PROGRAM (TITLE XVIII, PART B INPATIENT ROUTINE COSTS ONLY)						
Hospital Inpatient Routine Services:						
29.00	ADULTS & PEDIATRICS	0	0	0		29.00
30.00	Swing Bed - SNF	0	0			30.00
31.00	Swing Bed - NF					31.00
32.00	INTENSIVE CARE UNIT	0	0	0		32.00
33.00	CORONARY CARE UNIT	0	0	0		33.00
34.00	BURN INTENSIVE CARE UNIT	0	0	0		34.00
35.00	SURGICAL INTENSIVE CARE UNIT	0	0	0		35.00
36.00	OTHER SPECIAL CARE (SPECIFY)					36.00
37.00	Subtotal (sum of lines 29, and 32 through 36)		0	0		37.00
38.00	SUBPROVIDER - IPF					38.00
39.00	SUBPROVIDER - IRF	0	0	0		39.00
40.00	SUBPROVIDER	0	0	0		40.00
41.00	SKILLED NURSING FACILITY	0	0	0		41.00
42.00	Total (sum of lines 37 through 41)		0	0		42.00

APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

Provider CCN: 14-0250

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

Worksheet D-2

Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description	In Approved Teaching Program	Total Title XVIII Costs		
	Amount	(to Wkst. E, Part B -)	(col. 2 + col. 4)	
	4.00	5.00	6.00	
PART III - SUMMARY FOR TITLE XVIII (TO BE COMPLETED ONLY IF BOTH PARTS I AND II ARE USED)				
Hospital				
43.00 Inpatient	0		0	43.00
44.00 Outpatient				44.00
45.00 Total Hospital (sum of lines 43 and 44)	0	line 22	0	45.00
46.00 SUBPROVIDER - IPF				46.00
47.00 SUBPROVIDER - IRF	0	line 22	0	47.00
48.00 SUBPROVIDER	0	line 22	0	48.00
49.00 SKILLED NURSING FACILITY	0	line 22	0	49.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		31,627,139	30.00
31.00	03100	INTENSIVE CARE UNIT		10,914,687	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.136771	12,689,056	1,735,495 50.00
53.00	05300	ANESTHESIOLOGY	0.018501	2,198,406	40,673 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083887	13,685,949	1,148,073 54.00
56.00	05600	RADIOISOTOPE	0.125407	1,097,950	137,691 56.00
56.01	05601	ULTRASOUND	0.094858	510,895	48,462 56.01
57.00	05700	CT SCAN	0.000000	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.156988	3,896,926	611,771 59.00
60.00	06000	LABORATORY	0.129544	12,476,443	1,616,248 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.141160	1,211,089	170,957 62.00
64.00	06400	INTRAVENOUS THERAPY	0.590386	345,311	203,867 64.00
65.00	06500	RESPIRATORY THERAPY	0.242806	4,294,411	1,042,709 65.00
66.00	06600	PHYSICAL THERAPY	0.258279	2,669,552	689,489 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227165	831,721	188,938 67.00
68.00	06800	SPEECH PATHOLOGY	0.312841	659,954	206,461 68.00
69.00	06900	ELECTROCARDIOLOGY	0.103219	3,355,465	346,348 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.255819	241,582	61,801 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737348	4,638,273	3,420,021 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.381047	5,533,122	2,108,380 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181973	22,613,863	4,115,112 73.00
74.00	07400	RENAL DIALYSIS	0.280777	1,674,952	470,288 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.340946	280,656	95,689 75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.496445	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0.707111	7,830	5,537 76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.277043	34,697	9,613 90.00
91.00	09100	EMERGENCY	0.113191	9,606,751	1,087,398 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303830	4,709,300	1,430,827 92.00
93.00	04950	SLEEP LAB	0.000000	0	0 93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		109,264,154	20,991,848 200.00
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)		109,264,154	20,991,848 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0250 Component CCN: 14-5599	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 2:00 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.136771	18,332	50.00
53.00	05300	ANESTHESIOLOGY	0.018501	2,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083887	81,555	54.00
56.00	05600	RADIOISOTOPE	0.125407	8,103	56.00
56.01	05601	ULTRASOUND	0.094858	6,983	56.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.156988	0	59.00
60.00	06000	LABORATORY	0.129544	282,037	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.141160	5,629	62.00
64.00	06400	INTRAVENOUS THERAPY	0.590386	662	64.00
65.00	06500	RESPIRATORY THERAPY	0.242806	179,404	65.00
66.00	06600	PHYSICAL THERAPY	0.258279	836,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227165	1,025,522	67.00
68.00	06800	SPEECH PATHOLOGY	0.312841	33,739	68.00
69.00	06900	ELECTROCARDIOLOGY	0.103219	12,795	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.255819	2,560	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737348	286,247	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.381047	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181973	529,393	73.00
74.00	07400	RENAL DIALYSIS	0.280777	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.340946	623	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.496445	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.707111	295	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.277043	13,879	90.00
91.00	09100	EMERGENCY	0.113191	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303830	0	92.00
93.00	04950	SLEEP LAB	0.000000	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,327,152	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)		3,327,152	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/23/2018 2:00 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,533,827	30.00
31.00	03100	INTENSIVE CARE UNIT		1,414,743	31.00
32.00	03200	CORONARY CARE UNIT		0	32.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	34.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		837,748	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.136771	664,965	50.00
53.00	05300	ANESTHESIOLOGY	0.018501	249,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.083887	1,412,865	54.00
56.00	05600	RADIOISOTOPE	0.125407	104,478	56.00
56.01	05601	ULTRASOUND	0.094858	115,285	56.01
57.00	05700	CT SCAN	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.156988	348,918	59.00
60.00	06000	LABORATORY	0.129544	1,960,962	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.141160	178,685	62.00
64.00	06400	INTRAVENOUS THERAPY	0.590386	39,941	64.00
65.00	06500	RESPIRATORY THERAPY	0.242806	350,389	65.00
66.00	06600	PHYSICAL THERAPY	0.258279	117,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.227165	40,665	67.00
68.00	06800	SPEECH PATHOLOGY	0.312841	25,710	68.00
69.00	06900	ELECTROCARDIOLOGY	0.103219	322,093	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.255819	20,435	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.737348	261,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.381047	113,689	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181973	2,222,659	73.00
74.00	07400	RENAL DIALYSIS	0.280777	44,245	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.340946	35,157	75.00
76.00	03560	PULMONARY FUNCTION TESTING	0.496445	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.707111	1,740	76.97
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	0.277043	0	90.00
91.00	09100	EMERGENCY	0.113191	1,145,861	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.303830	387,225	92.00
93.00	04950	SLEEP LAB	0.000000	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,165,301	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)		10,165,301	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		22,692,217	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		8,085,239	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)		562,594	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)		209.03	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)		3.51	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.04	31.00
32.00	Sum of lines 30 and 31		23.55	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.64	33.00
34.00	Disproportionate share adjustment (see instructions)		664,793	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 2:00 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		1,428,723	1,666,983	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		1,068,606	420,171	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,488,777		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)		33,493,620		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)			33,493,620	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			2,640,984	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			3,232	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			36,137,836	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			36,137,836	61.00
62.00	Deductibles billed to program beneficiaries			2,974,468	62.00
63.00	Coinurance billed to program beneficiaries			192,423	63.00
64.00	Allowable bad debts (see instructions)			1,008,343	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			655,423	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			624,533	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			33,626,368	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 PER PS&R			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)			-83,139	70.93
70.94	HRR adjustment amount (see instructions)			-98,910	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		33,444,319	71.00
71.01	Sequestration adjustment (see instructions)		668,886	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		32,909,168	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)		-133,735	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		603,000	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		60,695	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,079,778	2.00
3.00	OPPS payments		14,311,181	3.00
4.00	Outlier payment (see instructions)		19,854	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.778	5.00
6.00	Line 2 times line 5		11,732,067	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		60,695	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		189,859	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)		189,859	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)		189,859	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		129,164	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)		60,695	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)		14,331,035	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		27,255	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,672,680	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)		11,691,795	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)		11,691,795	30.00
31.00	Primary payer payments		2,319	31.00
32.00	Subtotal (line 30 minus line 31)		11,689,476	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)		712,826	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		463,337	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		397,016	36.00
37.00	Subtotal (see instructions)		12,152,813	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		12,152,813	40.00
40.01	Sequestration adjustment (see instructions)		243,056	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		11,972,380	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-62,623	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: 14-0250 Component CCN: 14-5599	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		0	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)			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)		0	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)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	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)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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 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)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		0	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0250

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

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		32,974,717		11,972,380	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	08/24/2017	65,549		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)		-65,549		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)		32,909,168		11,972,380	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		133,735		62,623	6.02	
7.00	Total Medicare program liability (see instructions)		32,775,433		11,909,757	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: 14-0250
Component CCN: 14-5599

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

Worksheet E-1
Part I
Date/Time Prepared:
5/23/2018 2:00 pm

Title XVIII
Skilled Nursing Facility

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					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		1,205,287		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,205,287		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		22,050		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,227,337		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			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: 14-0250 Component CCN: 14-5599	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VI Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,266,236	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,266,236	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		36,351	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		22,500	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,252,385	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,252,385	15.00
15.01	Sequestration adjustment (see instructions)		25,048	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		1,205,287	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		22,050	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0250

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

Worksheet G

Date/Time Prepared:
5/23/2018 2:00 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	229,643,000	0	0	0	1.00
2.00	Temporary investments	82,664,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	672,820,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	191,459,000	0	0	0	9.00
10.00	Due from other funds	23,729,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,200,315,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	158,161,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,982,049,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,494,843,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,508,470,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,126,583,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,829,122,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	444,752,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,273,874,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,600,772,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	346,603,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	386,896,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	88,828,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	421,544,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,243,871,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,493,648,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	848,770,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,342,418,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,586,289,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,014,483,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	5,014,483,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,600,772,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0250

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

Worksheet G-1

Date/Time Prepared:
5/23/2018 2:00 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		4,173,106,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		14,685,754			2.00
3.00	Total (sum of line 1 and line 2)		4,187,791,754		0	3.00
4.00	SYSTEM ADJUSTMENT	826,691,246		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)		826,691,246		0	10.00
11.00	Subtotal (line 3 plus line 10)		5,014,483,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,014,483,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	SYSTEM ADJUSTMENT		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: 14-0250

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/23/2018 2:00 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	97,946,887		97,946,887	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	5,970,135		5,970,135	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)	103,917,022		103,917,022	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	27,663,249		27,663,249	11.00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	27,663,249		27,663,249	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	131,580,271		131,580,271	17.00
18.00	Ancillary services	275,948,774	321,384,832	597,333,606	18.00
19.00	Outpatient services	40,451,389	118,203,514	158,654,903	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON RE - ACCRUAL	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	447,980,434	439,588,346	887,568,780	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		218,985,953		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		218,985,953		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0250

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

Worksheet G-3

Date/Time Prepared:
5/23/2018 2:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	887,568,780	1.00
2.00	Less contractual allowances and discounts on patients' accounts	655,624,303	2.00
3.00	Net patient revenues (line 1 minus line 2)	231,944,477	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	218,985,953	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,958,524	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	795	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	434,901	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	1,949	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	52,672	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	12,577	21.00
22.00	Rental of hospital space	505,351	22.00
23.00	Governmental appropriations	8,066	23.00
24.00	OTHER OPERATING INCOME	710,919	24.00
25.00	Total other income (sum of lines 6-24)	1,727,230	25.00
26.00	Total (line 5 plus line 25)	14,685,754	26.00
27.00	CORPORATE EXPENSES	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)	14,685,754	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 14-0250

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

Worksheet 1-5

Date/Time Prepared:
5/23/2018 2:00 pm

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

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0250	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/23/2018 2:00 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,495,200	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		23,769	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)		117.14	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)		3.51	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		20.04	8.00
9.00	Sum of lines 7 and 8		23.55	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.89	10.00
11.00	Disproportionate share adjustment (see instructions)		122,015	11.00
12.00	Total prospective capital payments (see instructions)		2,640,984	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