

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: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/30/2017 11:26 am
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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: 11/30/2017 Time: 11:26 am

PART II - CERTIFICATION

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

CERTIFICATION BY 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 ALEXIAN BROTHERS MEDICAL CENTER (14-0258) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	150,455	-212,671	18,054	0	1.00
2.00 Subprovider - IPF	0	28,021	0		0	2.00
3.00 Subprovider - IRF	0	42,685	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	6,134		0	9.00
200.00 Total	0	221,161	-206,537	18,054	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/30/2017 11:23 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 800 BIESTERFIELD ROAD			PO Box:						1.00
2.00	City: ELK GROVE VILLAGE			State: IL		Zip Code: 60007-3397		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	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	ALEXIAN BROTHERS MEDICAL CENTER	140258	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	ABMC OLDER ADULT BEHAVIORAL HEALTH	14S258	16974	4	07/01/2014	N	P	O	4.00
5.00	Subprovider - IRF	ALEXIAN REHABILITATION UNIT	14T258	16974	5	01/01/1980	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	ALEXIAN BROTHERS HOME HEALTH AGENCY	147583	16974		06/01/1994	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	ALEXIAN BROTHERS HOSPICE	141632	16974		01/01/1976				14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2016		06/30/2017		20.00
21.00	Type of Control (see instructions)					1				21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y		Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					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 days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,468	868	36	0	8,667	0			24.00

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		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		
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.	414	97	0	0	658		25.00	
							Urban/Rural	Date of Geogr	
							1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
							Beginning:	Ending:	
							1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
							Y/N	Y/N	
							1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
							V	XVIII	XIX
							1.00	2.00	3.00
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					Y			60.00
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00					61.01

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
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	
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 and enter in column 4, direct GME FTE unweighted count.						61.10	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 and enter in column 4, direct GME FTE unweighted count.						61.20	0.00
							1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						62.01	0.00
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						63.00	N
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.000000
			Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	4.00	5.00	

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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
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		
		Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.		N			70.00	
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00	
		Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.		Y			75.00	

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		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
		1.00			
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N			87.00
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	N			92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.	N			110.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N	0		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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

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		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.		N	N
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.		N	122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
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	149019
		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: ALEXIAN BROTHERS HOSPITAL NETWORK	Contractor's Name: 14-9019	Contractor's Number: 05001	
142.00	Street: 3040 SALT CREEK LANE	PO Box:		
143.00	City: ARLINGTON HEIGHTS	State: IL	Zip Code:	60005
			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/30/2017 11:23 am		
1.00								
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
1.00								
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	
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)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.25	169.00
		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)	10/01/2015	09/30/2016				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: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/30/2017 11:23 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			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	11/03/2016	Y	11/03/2016
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: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/30/2017 11:23 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	LEONE REIMBURSEMENT&CONSULTING, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023		TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/30/2017 11:23 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0258

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

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2017 11:23 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	221	80,665	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)		221	80,665	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	36	13,140	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		257	93,805	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF	41.00	72	26,280		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		353				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0258

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

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2017 11:23 am

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)	32,713	3,752	64,081			1.00
2.00 HMO and other (see instructions)	7,467	8,260				2.00
3.00 HMO IPF Subprovider	831	968				3.00
4.00 HMO IRF Subprovider	1,388	1,889				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)	32,713	3,752	64,081			7.00
8.00 INTENSIVE CARE UNIT	4,235	226	9,702			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		801	5,405			13.00
14.00 Total (see instructions)	36,948	4,779	79,188	0.00	2,072.08	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	3,912	37	5,466	0.00	33.44	16.00
17.00 SUBPROVIDER - IRF	14,848	207	21,457	0.00	139.47	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	42,907	0	58,795	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	2,244.99	27.00
28.00 Observation Bed Days		0	2,920			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0258

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

Worksheet S-3
Part I
Date/Time Prepared:
11/30/2017 11:23 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	6,850	467	16,135	1.00
2.00 HMO and other (see instructions)				1,417	1,580		2.00
3.00 HMO IPF Subprovider					71		3.00
4.00 HMO IRF Subprovider					145		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		6,850	467	16,135	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		295	3	409	16.00
17.00 SUBPROVIDER - IRF	0.00	0		0	14	1,610	17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part II Date/Time Prepared: 11/30/2017 11:23 am			
	Worksheet A Line Number	Amount Reported	Reclassifi- cation of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	142,425,312	0	142,425,312	4,087,889.00	34.84	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		1,277,164	0	1,277,164	9,460.00	135.01	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		22,135,250	0	22,135,250	747,319.00	29.62	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		3,487,211	0	3,487,211	14,898.00	234.07	11.00
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		34,194,658	0	34,194,658	812,074.00	42.11	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		28,715,073	0	28,715,073			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		6,077,294	0	6,077,294			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		8,319,472	0	8,319,472			25.50
25.51	Related organization wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0258

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

Worksheet S-3
Part II
Date/Time Prepared:
11/30/2017 11:23 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	579,930	0	579,930	16,569.00	35.00	26.00
27.00	Administrative & General	5.00	8,799,845	0	8,799,845	268,064.00	32.83	27.00
28.00	Administrative & General under contract (see inst.)		2,586,821	0	2,586,821	21,047.00	122.91	28.00
29.00	Maintenance & Repairs	6.00	845,130	0	845,130	49,327.00	17.13	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		2,488,568	0	2,488,568	190,720.00	13.05	33.00
34.00	Dietary	10.00	65,960	-23,840	42,120	1,333.00	31.60	34.00
35.00	Dietary under contract (see instructions)		5,798,508	0	5,798,508	201,895.00	28.72	35.00
36.00	Cafeteria	11.00	0	23,840	23,840	754.00	31.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,766,596	0	1,766,596	43,402.00	40.70	38.00
39.00	Central Services and Supply	14.00	774,290	0	774,290	40,000.00	19.36	39.00
40.00	Pharmacy	15.00	4,538,456	0	4,538,456	106,183.00	42.74	40.00
41.00	Medical Records & Medical Records Library	16.00	3,203,325	0	3,203,325	109,104.00	29.36	41.00
42.00	Social Service	17.00	2,532,951	0	2,532,951	55,219.00	45.87	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0258

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

Worksheet S-3
Part III
Date/Time Prepared:
11/30/2017 11:23 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	152,022,045	0	152,022,045	4,492,091.00	33.84	1.00
2.00	Excluded area salaries (see instructions)	22,135,250	0	22,135,250	747,319.00	29.62	2.00
3.00	Subtotal salaries (line 1 minus line 2)	129,886,795	0	129,886,795	3,744,772.00	34.68	3.00
4.00	Subtotal other wages & related costs (see inst.)	37,681,869	0	37,681,869	826,972.00	45.57	4.00
5.00	Subtotal wage-related costs (see inst.)	37,034,545	0	37,034,545	0.00	28.51	5.00
6.00	Total (sum of lines 3 thru 5)	204,603,209	0	204,603,209	4,571,744.00	44.75	6.00
7.00	Total overhead cost (see instructions)	33,980,380	0	33,980,380	1,103,617.00	30.79	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2017 11:23 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			2,819,042 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)			1,744,716 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			89,188 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			17,324,331 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			0 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			293,447 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			67,794 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)			398,176 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			1,358,026 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			10,374,310 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			323,337 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			34,792,367 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COST			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part V Date/Time Prepared: 11/30/2017 11:23 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,487,211	34,792,367	1.00
2.00	Hospital	3,487,211	28,715,073	2.00
3.00	Subprovider - IPF	0	538,327	3.00
4.00	Subprovider - IRF	0	1,959,814	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	3,579,153	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0258 Component CCN: 14-7583		Period: From 07/01/2016 To 06/30/2017		Worksheet S-4 Date/Time Prepared: 11/30/2017 11:23 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			COOK		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	3,755	0	765	4,520 1.00	
2.00	Unduplicated Census Count (see instructions)	0.00	1,999.00	0.00	1,215.00	3,214.00 2.00	
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		1.00	0.00	1.00 3.00	
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00 4.00	
5.00	Other Administrative Personnel			26.31	0.00	26.31 5.00	
6.00	Direct Nursing Service			64.48	0.00	64.48 6.00	
7.00	Nursing Supervisor			0.00	0.00	0.00 7.00	
8.00	Physical Therapy Service			43.27	0.00	43.27 8.00	
9.00	Physical Therapy Supervisor			0.00	0.00	0.00 9.00	
10.00	Occupational Therapy Service			15.68	0.00	15.68 10.00	
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00 11.00	
12.00	Speech Pathology Service			3.32	0.00	3.32 12.00	
13.00	Speech Pathology Supervisor			0.00	0.00	0.00 13.00	
14.00	Medical Social Service			2.19	0.00	2.19 14.00	
15.00	Medical Social Service Supervisor			0.00	0.00	0.00 15.00	
16.00	Home Health Aide			12.42	0.00	12.42 16.00	
17.00	Home Health Aide Supervisor			0.00	0.00	0.00 17.00	
18.00	Other (specify)			0.00	0.00	0.00 18.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3		19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974		20.00	
20.01				20994		20.01	
20.02				29404		20.02	
				Full Episodes			
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	16,579	583	676	404	18,242 21.00	
22.00	Skilled Nursing Visit Charges	2,818,277	99,110	114,920	66,810	3,099,117 22.00	
23.00	Physical Therapy Visits	13,547	318	217	296	14,378 23.00	
24.00	Physical Therapy Visit Charges	2,573,930	60,420	41,230	56,240	2,731,820 24.00	
25.00	Occupational Therapy Visits	4,578	237	18	110	4,943 25.00	
26.00	Occupational Therapy Visit Charges	869,820	45,030	3,420	20,900	939,170 26.00	
27.00	Speech Pathology Visits	722	42	5	8	777 27.00	
28.00	Speech Pathology Visit Charges	137,180	7,980	950	1,520	147,630 28.00	
29.00	Medical Social Service Visits	488	42	11	13	554 29.00	
30.00	Medical Social Service Visit Charges	146,400	12,600	3,300	3,900	166,200 30.00	
31.00	Home Health Aide Visits	3,679	267	13	54	4,013 31.00	
32.00	Home Health Aide Visit Charges	440,880	32,040	1,560	6,480	480,960 32.00	
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	39,593	1,489	940	885	42,907 33.00	
34.00	Other Charges	253,442	29,960	8,416	4,348	296,166 34.00	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	7,239,929	287,140	173,796	160,198	7,861,063 35.00	
36.00	Total Number of Episodes (standard/non outlier)	2,344		339	71	2,754 36.00	
37.00	Total Number of Outlier Episodes		33		3	36 37.00	
38.00	Total Non-Routine Medical Supply Charges	253,442	29,960	8,416	4,348	296,166 38.00	

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA		Provider CCN: 14-0258 Hospice CCN: 14-1632	Period: From 07/01/2016 To 06/30/2017	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 11/30/2017 11:23 am
		Hospice I		

	Unduplicated Days	Hospice I				Total (sum of cols. 1, 2 & 5)	
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility		
		1.00	2.00	3.00	4.00		
PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care						1.00
2.00	Hospice Routine Home Care						2.00
3.00	Hospice Inpatient Respite Care						3.00
4.00	Hospice General Inpatient Care						4.00
5.00	Total Hospice Days						5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care						6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare						7.00
8.00	Average Length of Stay (line 5 / line 6)						8.00
9.00	Unduplicated census count						9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	24,664	1,348	1,195	27,207	11.00
12.00	Hospice Inpatient Respite Care	296	0	26	322	12.00
13.00	Hospice General Inpatient Care	2,357	195	372	2,924	13.00
14.00	Total Hospice Days	27,317	1,543	1,593	30,453	14.00
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/30/2017 11:23 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.206795	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			32,195,777	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			217,337,370	6.00
7.00	Medicaid cost (line 1 times line 6)			44,944,281	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)			12,748,504	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)			12,748,504	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)	20,178,709	0	20,178,709	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,172,856	0	4,172,856	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)	4,172,856	0	4,172,856	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,770,514	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,118,865	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,721,331	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			1,049,183	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			819,432	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,992,288	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			17,740,792	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0258

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

Worksheet A

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		10,412,888		15,732,712	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	7,595,328	7,595,328	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	579,930	22,816,504	-41	23,396,393	4.00
5.01	00540	NONPATIENT TELEPHONES	683,014	501,054	-152	1,183,916	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	1,276,832	5,104	1,281,936	5.03
5.04	00570	ADMINITTING	2,071,282	401,815	-5,789	2,467,308	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,260,486	396,225	-200	1,656,511	5.05
5.06	00590	ADMINISTRATIVE AND GENERAL	4,785,063	104,721,366	-2,551,185	106,955,244	5.06
6.00	00600	MAINTENANCE & REPAIRS	845,130	224,572	-27,330	1,042,372	6.00
7.00	00700	OPERATION OF PLANT	0	5,911,124	-152,562	5,758,562	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,300,000	1,300,000	8.00
9.00	00900	HOUSEKEEPING	0	6,825,655	-1,301,468	5,524,187	9.00
10.00	01000	DIETARY	65,960	7,031,080	7,097,040	5,289,053	10.00
11.00	01100	CAFETERIA	0	1,260,974	1,789,556	3,050,530	11.00
13.00	01300	NURSING ADMINISTRATION	1,766,596	1,062,871	2,829,467	2,761,712	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	774,290	1,810,389	2,584,679	965,886	14.00
15.00	01500	PHARMACY	4,538,456	22,403,340	26,941,796	5,390,035	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,203,325	1,830,016	5,033,341	5,027,780	16.00
17.00	01700	SOCIAL SERVICE	2,532,951	268,511	2,801,462	2,799,615	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	365,932	62,589	428,521	428,521	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	32,688,374	6,458,114	39,146,488	37,927,433	30.00
31.00	03100	INTENSIVE CARE UNIT	9,226,882	1,950,344	11,177,226	10,134,906	31.00
40.00	04000	SUBPROVIDER - I/PF	1,808,697	456,455	2,265,152	2,267,046	40.00
41.00	04100	SUBPROVIDER - I/RF	8,844,951	11,798,884	20,643,835	20,118,993	41.00
43.00	04300	NURSERY	1,387,029	967,769	2,354,798	2,242,210	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,027,772	28,034,661	36,062,433	11,016,994	50.00
50.01	05001	GAMMA KNIFE	416,552	1,920,014	2,336,566	2,328,414	50.01
50.02	03330	ENDOSCOPY	1,907,410	2,495,799	4,403,209	2,871,157	50.02
51.00	05100	RECOVERY ROOM	1,504,487	215,274	1,719,761	1,642,347	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,073,515	630,690	2,704,205	2,281,676	52.00
53.00	05300	ANESTHESIOLOGY	0	765,457	765,457	184,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,040,405	651,790	2,692,195	2,508,387	54.00
54.01	03630	ULTRA SOUND	1,076,823	172,316	1,249,139	1,177,367	54.01
54.02	05401	PET SCAN	110,208	620,813	731,021	119,205	54.02
54.03	03480	ONCOLOGY	1,264,658	773,022	2,037,680	1,440,774	54.03
54.04	03440	MAMMOGRAPHY	867,205	337,830	1,205,035	1,081,864	54.04
56.00	05600	RADIOISOTOPE	390,783	775,629	1,166,412	450,126	56.00
57.00	05700	CT SCAN	1,333,056	497,990	1,831,046	1,488,103	57.00
58.00	05800	MRI	876,834	592,856	1,469,690	1,238,097	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,265,312	21,459,578	25,724,890	7,219,539	59.00
60.00	06000	LABORATORY	6,529,346	9,217,852	15,747,198	15,322,788	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	516,261	1,680,803	2,197,064	2,189,695	63.00
64.00	06400	INTRAVENOUS THERAPY	986,930	1,322,151	2,309,081	1,819,165	64.00
65.00	06500	RESPIRATORY THERAPY	2,523,320	709,966	3,233,286	2,912,948	65.00
66.00	06600	PHYSICAL THERAPY	784,021	70,007	854,028	530,957	66.00
66.01	06601	REHAB OUTPATIENT	2,091,593	207,259	2,298,852	2,269,934	66.01
66.02	06602	REHAB MED SURGICAL	2,009,187	170,817	2,180,004	2,177,815	66.02
69.00	06900	ELECTROCARDIOLOGY	771,460	346,833	1,118,293	1,059,305	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	153,197	56,053	209,250	196,048	70.00
70.01	07001	NEUROMEG	0	25,268	25,268	0	70.01
70.02	07002	SLEEP LAB	645,238	155,969	801,207	710,862	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	30,675,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,693,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,738,680	73.00
74.00	07400	RENAL DIALYSIS	46,534	498,037	544,571	527,833	74.00
76.97	07697	CARDIAC REHABILITATION	463,430	76,163	539,593	514,665	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,237,269	565,371	1,802,640	1,468,022	90.00
90.01	09001	DAY REHAB	885,145	94,925	980,070	973,719	90.01
90.02	09002	IMAGING CENTERS	761,685	588,367	1,350,052	1,262,372	90.02
90.03	09003	COUMADIN CLINIC	195,870	51,490	247,360	215,176	90.03
90.04	09004	WOUND CLINIC	593,614	1,467,513	2,061,127	831,587	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	1,307,164	947,232	2,254,396	2,098,541	90.05
91.00	09100	EMERGENCY	5,225,010	2,793,339	8,018,349	6,771,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet A Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	6,866,175	1,558,415	8,424,590	-237,741	8,186,849	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		7,337,352	7,337,352	-7,337,352	0	113.00
116.00	11600	HOSPICE	3,785,105	2,709,114	6,494,219	-268,108	6,226,111	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	141,960,922	303,443,386	445,404,308	315,338	445,719,646	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	158,824	220,737	379,561	-551	379,010	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	305,566	6,714,406	7,019,972	-314,787	6,705,185	192.00
200.00		TOTAL (SUM OF LINES 118-199)	142,425,312	310,378,529	452,803,841	0	452,803,841	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0258

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

Worksheet A
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-128,988	15,603,724	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,176,262	9,771,590	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	23,396,393	4.00
5.01	00540	NONPATIENT TELEPHONES	-364,467	819,449	5.01
5.02	00550	DATA PROCESSING	11,973,847	11,973,847	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	4,776,427	6,058,363	5.03
5.04	00570	ADMINISTRATIVE	0	2,467,308	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	8,211,519	9,868,030	5.05
5.06	00590	ADMINISTRATIVE AND GENERAL	-25,669,077	81,286,167	5.06
6.00	00600	MAINTENANCE & REPAIRS	-93,906	948,466	6.00
7.00	00700	OPERATION OF PLANT	7,087,992	12,846,554	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,300,000	8.00
9.00	00900	HOUSEKEEPING	0	5,524,187	9.00
10.00	01000	DIETARY	0	5,289,053	10.00
11.00	01100	CAFETERIA	-2,013,807	1,036,723	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,761,712	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	965,886	14.00
15.00	01500	PHARMACY	-10,137	5,379,898	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,940	5,025,840	16.00
17.00	01700	SOCIAL SERVICE	-24,971	2,774,644	17.00
23.00	02300	PARAMED PRGM-(SPECIFY)	-3,100	425,421	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-183,505	37,743,928	30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,134,906	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,267,046	40.00
41.00	04100	SUBPROVIDER - IRF	-503,756	19,615,237	41.00
43.00	04300	NURSERY	-725,670	1,516,540	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	11,016,994	50.00
50.01	05001	GAMMA KNIFE	0	2,328,414	50.01
50.02	03330	ENDOSCOPY	0	2,871,157	50.02
51.00	05100	RECOVERY ROOM	0	1,642,347	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,281,676	52.00
53.00	05300	ANESTHESIOLOGY	0	184,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,834	2,496,553	54.00
54.01	03630	ULTRA SOUND	0	1,177,367	54.01
54.02	05401	PET SCAN	0	119,205	54.02
54.03	03480	ONCOLOGY	0	1,440,774	54.03
54.04	03440	MAMMOGRAPHY	0	1,081,864	54.04
56.00	05600	RADIOISOTOPE	0	450,126	56.00
57.00	05700	CT SCAN	0	1,488,103	57.00
58.00	05800	MRI	0	1,238,097	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	7,219,539	59.00
60.00	06000	LABORATORY	-4,241,370	11,081,418	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,189,695	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,819,165	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,912,948	65.00
66.00	06600	PHYSICAL THERAPY	0	530,957	66.00
66.01	06601	REHAB OUTPATIENT	-5,682	2,264,252	66.01
66.02	06602	REHAB MED SURGICAL	0	2,177,815	66.02
69.00	06900	ELECTROCARDIOLOGY	0	1,059,305	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-23,734	172,314	70.00
70.01	07001	NEUROLOG	0	0	70.01
70.02	07002	SLEEP LAB	0	710,862	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	30,675,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,693,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,738,680	73.00
74.00	07400	RENAL DIALYSIS	0	527,833	74.00
76.97	07697	CARDIAC REHABILITATION	0	514,665	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHIOTHERAPY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,468,022	90.00
90.01	09001	DAY REHAB	0	973,719	90.01
90.02	09002	IMAGING CENTERS	0	1,262,372	90.02
90.03	09003	COUMADIN CLINIC	0	215,176	90.03
90.04	09004	WOUND CLINIC	-39,591	791,996	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	-49,864	2,048,677	90.05
91.00	09100	EMERGENCY	-73,056	6,698,403	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0258

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

Worksheet A
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	0	8,186,849	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	6,226,111	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	57,592	445,777,238	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	379,010	190.00
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-3,174,250	3,530,935	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,116,658	449,687,183	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	20,738,680	1.00
	TOTALS		0	20,738,680	
B - BED RENTALS					
1.00	ADULTS & PEDIATRICS	30.00	0	425,293	1.00
2.00	SUBPROVIDER - IPF	40.00	0	46,186	2.00
3.00	SUBPROVIDER - IRF	41.00	0	138,557	3.00
	TOTALS		0	610,036	
C - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	1,300,000	1.00
	TOTALS		0	1,300,000	
E - SHARED DIETARY					
1.00	CAFETERIA	11.00	23,840	1,765,716	1.00
	TOTALS		23,840	1,765,716	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,057,500	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,595,328	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
47.00		0.00	0	0	47.00
48.00		0.00	0	0	48.00
49.00		0.00	0	0	49.00
50.00		0.00	0	0	50.00
	TOTALS		0	10,652,828	
G - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	26,693,739	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

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
	TOTALS		0	26,693,739	
H - SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	30,675,107	1.00
2.00	PURCHASING RECEIVING AND STORES	5.03	0	685,544	2.00
3.00	ADMINISTRATIVE AND GENERAL	5.06	0	183,899	3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	27,425	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
41.00		0.00	0	0	41.00
42.00		0.00	0	0	42.00
43.00		0.00	0	0	43.00
44.00		0.00	0	0	44.00
45.00		0.00	0	0	45.00
46.00		0.00	0	0	46.00
47.00		0.00	0	0	47.00
48.00		0.00	0	0	48.00
49.00		0.00	0	0	49.00
50.00		0.00	0	0	50.00
51.00		0.00	0	0	51.00
52.00		0.00	0	0	52.00
53.00		0.00	0	0	53.00
54.00		0.00	0	0	54.00
55.00		0.00	0	0	55.00
56.00		0.00	0	0	56.00
	TOTALS		0	31,571,975	
J - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,337,352	1.00
	TOTALS		0	7,337,352	

RECLASSIFICATIONS

Provider CCN: 14-0258

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

Worksheet A-6

Date/Time Prepared:
11/30/2017 11:23 am

		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
	L - NEUROMEG					
1.00	ADMINISTRATIVE AND GENERAL		5.06	0	2,722	1.00
	TOTALS			0	2,722	
500.00	Grand Total: Increases			23,840	100,673,048	500.00

RECLASSIFICATIONS

Provider CCN: 14-0258

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

Worksheet A-6
Date/Time Prepared:
11/30/2017 11:23 am

Decreases						Wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other				
6.00	7.00	8.00	9.00	10.00			
A - CHARGEABLE DRUGS							
1.00	PHARMACY	15.00	0	20,738,680	0		1.00
	TOTALS		0	20,738,680			
B - BED RENTALS							
1.00	PURCHASING RECEIVING AND STORES	5.03	0	610,036	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	610,036			
C - LAUNDRY							
1.00	HOUSEKEEPING	9.00	0	1,300,000	0		1.00
	TOTALS		0	1,300,000			
E - SHARED DIETARY							
1.00	DIETARY	10.00	23,840	1,765,716	0		1.00
	TOTALS		23,840	1,765,716			
F - DEPRECIATION							
1.00	ADMINISTRATIVE AND GENERAL	5.06	0	2,737,770	9		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	25,609	9		2.00
3.00	OPERATION OF PLANT	7.00	0	152,299	0		3.00
4.00	HOUSEKEEPING	9.00	0	915	0		4.00
5.00	DIETARY	10.00	0	16,703	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	4,171	0		6.00
7.00	PHARMACY	15.00	0	25,412	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,511	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	27,906	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	10,849	0		10.00
11.00	SUBPROVIDER - IRF	41.00	0	461,819	0		11.00
12.00	NURSERY	43.00	0	6,969	0		12.00
13.00	OPERATING ROOM	50.00	0	505,074	0		13.00
14.00	GAMMA KNIFE	50.01	0	143	0		14.00
15.00	ENDOSCOPY	50.02	0	31,034	0		15.00
16.00	RECOVERY ROOM	51.00	0	5,039	0		16.00
17.00	DELIVERY ROOM & LABOR ROOM	52.00	0	6,308	0		17.00
18.00	ANESTHESIOLOGY	53.00	0	119,501	0		18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	83,823	0		19.00
20.00	ULTRA SOUND	54.01	0	27,338	0		20.00
21.00	PET SCAN	54.02	0	124,691	0		21.00
22.00	ONCOLOGY	54.03	0	69,039	0		22.00
23.00	RADIOISOTOPE	56.00	0	626	0		23.00
24.00	CT SCAN	57.00	0	30,977	0		24.00
25.00	MRI	58.00	0	17,801	0		25.00
26.00	CARDIAC CATHETERIZATION	59.00	0	135,972	0		26.00
27.00	LABORATORY	60.00	0	156,924	0		27.00
28.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,683	0		28.00
29.00	INTRAVENOUS THERAPY	64.00	0	1,333	0		29.00
30.00	RESPIRATORY THERAPY	65.00	0	5,890	0		30.00
31.00	REHAB OUTPATIENT	66.01	0	6,355	0		31.00
32.00	ELECTROCARDIOLOGY	69.00	0	28,414	0		32.00
33.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,761	0		33.00
34.00	NEUROLOG	70.01	0	21,000	0		34.00
35.00	SLEEP LAB	70.02	0	1,452	0		35.00
36.00	CARDIAC REHABILITATION	76.97	0	8,369	0		36.00
37.00	CLINIC	90.00	0	13,888	0		37.00
38.00	DAY REHAB	90.01	0	337	0		38.00
39.00	IMAGING CENTERS	90.02	0	51,112	0		39.00
40.00	WOUND CLINIC	90.04	0	4,141	0		40.00
41.00	CARDIOVASCULAR IMAGING CENTERS	90.05	0	155,855	0		41.00
42.00	EMERGENCY	91.00	0	28,768	0		42.00
43.00	HOSPICE	116.00	0	94,308	0		43.00
44.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	551	0		44.00
45.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	342,212	0		45.00
46.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,075,028	9		46.00
47.00	PURCHASING RECEIVING AND STORES	5.03	0	360	0		47.00
48.00	ADMINISTRATIVE	5.04	0	872	0		48.00
49.00	MAMMOGRAPHY	54.04	0	5,255	0		49.00
50.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,661	0		50.00
	TOTALS		0	10,652,828			

RECLASSIFICATIONS

Provider CCN: 14-0258

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

Worksheet A-6
Date/Time Prepared:
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		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
G - IMPLANTS							
1.00	PURCHASING RECEIVING AND STORES	5.03	0	70,044	0		1.00
2.00	ADMINISTRATIVE AND GENERAL	5.06	0	36	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	104,202	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,252	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	8,064	0		5.00
6.00	ENDOSCOPY	50.02	0	117,156	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,261	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	18	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	12,099,629	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	2,601	0		10.00
11.00	OPERATING ROOM	50.00	0	13,185,028	0		11.00
12.00	CLINIC	90.00	0	91,840	0		12.00
13.00	WOUND CLINIC	90.04	0	1,005,100	0		13.00
14.00	EMERGENCY	91.00	0	4,508	0		14.00
TOTALS			0	26,693,739			
H - SUPPLIES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41	0		1.00
2.00	NONPATIENT TELEPHONES	5.01	0	152	0		2.00
3.00	ADMINISTRATIVE	5.04	0	4,917	0		3.00
4.00	CASHIERING/ACCOUNTS RECEIVABLE	5.05	0	200	0		4.00
5.00	MAINTENANCE & REPAIRS	6.00	0	1,721	0		5.00
6.00	OPERATION OF PLANT	7.00	0	263	0		6.00
7.00	HOUSEKEEPING	9.00	0	553	0		7.00
8.00	DIETARY	10.00	0	1,728	0		8.00
9.00	NURSING ADMINISTRATION	13.00	0	63,584	0		9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,501,930	0		10.00
11.00	PHARMACY	15.00	0	787,669	0		11.00
12.00	MEDICAL RECORDS & LIBRARY	16.00	0	50	0		12.00
13.00	SOCIAL SERVICE	17.00	0	1,847	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	1,614,190	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	0	1,023,407	0		15.00
16.00	SUBPROVIDER - IPF	40.00	0	44,292	0		16.00
17.00	SUBPROVIDER - IRF	41.00	0	201,580	0		17.00
18.00	NURSERY	43.00	0	105,619	0		18.00
19.00	OPERATING ROOM	50.00	0	342,927	0		19.00
20.00	GAMMA KNIFE	50.01	0	8,009	0		20.00
21.00	ENDOSCOPY	50.02	0	1,383,862	0		21.00
22.00	RECOVERY ROOM	51.00	0	72,375	0		22.00
23.00	DELIVERY ROOM & LABOR ROOM	52.00	0	412,960	0		23.00
24.00	ANESTHESIOLOGY	53.00	0	461,926	0		24.00
25.00	RADIOLOGY-DIAGNOSTIC	54.00	0	99,967	0		25.00
26.00	ULTRA SOUND	54.01	0	44,434	0		26.00
27.00	PET SCAN	54.02	0	487,125	0		27.00
28.00	ONCOLOGY	54.03	0	527,867	0		28.00
29.00	MAMMOGRAPHY	54.04	0	117,916	0		29.00
30.00	RADIOISOTOPE	56.00	0	715,660	0		30.00
31.00	CT SCAN	57.00	0	311,966	0		31.00
32.00	MRI	58.00	0	213,792	0		32.00
33.00	CARDIAC CATHETERIZATION	59.00	0	6,269,750	0		33.00
34.00	LABORATORY	60.00	0	267,486	0		34.00
35.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	5,686	0		35.00
36.00	INTRAVENOUS THERAPY	64.00	0	488,583	0		36.00
37.00	RESPIRATORY THERAPY	65.00	0	314,448	0		37.00
38.00	PHYSICAL THERAPY	66.00	0	188,972	0		38.00
39.00	REHAB OUTPATIENT	66.01	0	22,563	0		39.00
40.00	REHAB MED SURGICAL	66.02	0	2,189	0		40.00
41.00	ELECTROCARDIOLOGY	69.00	0	30,574	0		41.00
42.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,441	0		42.00
43.00	NEUROLOG	70.01	0	1,546	0		43.00
44.00	SLEEP LAB	70.02	0	88,893	0		44.00
45.00	OPERATING ROOM	50.00	0	11,012,410	0		45.00
46.00	RENAL DIALYSIS	74.00	0	16,738	0		46.00
47.00	CARDIAC REHABILITATION	76.97	0	16,559	0		47.00
48.00	CLINIC	90.00	0	228,890	0		48.00
49.00	DAY REHAB	90.01	0	6,014	0		49.00
50.00	IMAGING CENTERS	90.02	0	36,568	0		50.00
51.00	COUMADIN CLINIC	90.03	0	32,184	0		51.00
52.00	WOUND CLINIC	90.04	0	220,299	0		52.00
53.00	PHYSICAL THERAPY	66.00	0	131,498	0		53.00
54.00	EMERGENCY	91.00	0	1,213,614	0		54.00

Provider CCN: 14-0258

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

Worksheet A-6

Date/Time Prepared:
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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
55.00	HOSPICE	116.00	0	173,800	0		55.00
56.00	HOME HEALTH AGENCY	101.00	0	237,741	0		56.00
	TOTALS		0	31,571,975			
J - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	7,337,352	11		1.00
	TOTALS		0	7,337,352			
L - NEUROMEG							
1.00	NEUROMEG	70.01	0	2,722	0		1.00
	TOTALS		0	2,722			
500.00	Grand Total: Decreases		23,840	100,673,048			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0258

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

Worksheet A-7
Part I
Date/Time Prepared:
11/30/2017 11:23 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	10,100,000	0	0	0	0	1.00
2.00	Land Improvements	728,193	172,815	0	172,815	0	2.00
3.00	Buildings and Fixtures	180,654,412	2,560,536	0	2,560,536	0	3.00
4.00	Building Improvements	15,983,362	876,634	0	876,634	0	4.00
5.00	Fixed Equipment	2,127,203	0	0	0	0	5.00
6.00	Movable Equipment	60,120,958	7,753,325	0	7,753,325	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	269,714,128	11,363,310	0	11,363,310	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	269,714,128	11,363,310	0	11,363,310	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	10,100,000	0				1.00
2.00	Land Improvements	901,008	0				2.00
3.00	Buildings and Fixtures	183,214,948	0				3.00
4.00	Building Improvements	16,859,996	0				4.00
5.00	Fixed Equipment	2,127,203	0				5.00
6.00	Movable Equipment	67,874,283	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	281,077,438	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	281,077,438	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0258

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

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	10,412,888	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	10,412,888	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	10,412,888	1.00			
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00			
3.00	Total (sum of lines 1-2)	0	10,412,888	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0258

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

Worksheet A-7
Part III
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	199,493,170	0	199,493,170	0.768422	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	60,120,958	0	60,120,958	0.231578	0	2.00
3.00	Total (sum of lines 1-2)	259,614,128	0	259,614,128	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	13,815,463	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	9,771,590	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	23,587,053	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	1,788,261	0	0	0	15,603,724	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	9,771,590	2.00
3.00	Total (sum of lines 1-2)	1,788,261	0	0	0	25,375,314	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0258

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

Worksheet A-8

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center	Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-209,582	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		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	-1,055,829			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	10,852,500			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-2,013,807	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-1,940	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	2,224,130	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-2,638,776	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

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
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
34.03 WEIGHT MANAGEMENT	A	-158,270	ADMINISTRATIVE AND GENERAL	5.06		0	34.03
34.05 NON ALLOW PATIENT TRANSPORTATIO	A	-93,906	MAINTENANCE & REPAIRS	6.00		0	34.05
35.00 ALCOHOL	A	-6,000	ADMINISTRATIVE AND GENERAL	5.06		0	35.00
36.00 REAL ESTATE TAXES	A	-57,289	OPERATION OF PLANT	7.00		0	36.00
36.01 REAL ESTATE TAXES	A	-273,390	PHYSICIANS' PRIVATE OFFICES	192.00		0	36.01
36.02 REAL ESTATE TAXES	A	-113,466	PHYSICIANS' PRIVATE OFFICES	192.00		0	36.02
36.03 REAL ESTATE TAXES	A	-96,148	PHYSICIANS' PRIVATE OFFICES	192.00		0	36.03
36.04 REAL ESTATE TAXES	A	-138,212	ADMINISTRATIVE AND GENERAL	5.06		0	36.04
37.00 ANSWERING SERVICE	B	-364,467	NONPATIENT TELEPHONES	5.01		0	37.00
38.00 MISC & REFERENCE LAB INCOME	B	-4,241,370	LABORATORY	60.00		0	38.00
38.01 MISCELLANEOUS INCOME	B	-1,115,904	ADMINISTRATIVE AND GENERAL	5.06		0	38.01
38.02 MISCELLANEOUS INCOME	B	-11,834	RADIOLOGY-DIAGNOSTIC	54.00		0	38.02
38.03 PARAMEDICAL EDUCATION	B	-3,100	PARAMED ED PRGM-(SPECIFY)	23.00		0	38.03
38.04 MISCELLANEOUS INCOME	B	-24,971	SOCIAL SERVICE	17.00		0	38.04
38.05 MISCELLANEOUS INCOME	B	-503,756	SUBPROVIDER - I RF	41.00		0	38.05
38.09 MISC INCOME EXECERISE	B	-5,682	REHAB OUTPATIENT	66.01		0	38.09
38.10 MISCELLANEOUS INCOME	B	-10,137	PHARMACY	15.00		0	38.10
38.11 RENTAL REVENUE	B	-1,837,510	PHYSICIANS' PRIVATE OFFICES	192.00		0	38.11
38.12 RENTAL REVENUE	B	-312,919	CAP REL COSTS-BLDG & FIXT	1.00		9	38.12
39.00 PHYSICIAN PART B	A	-853,736	PHYSICIANS' PRIVATE OFFICES	192.00		0	39.00
40.00 GAIN ON SALE NON OPERATING ASSETS	B	-1,287	CAP REL COSTS-MVBLE EQUIP	2.00		9	40.00
44.00 LOBBYING PORTION OF DUES	A	-50,000	ADMINISTRATIVE AND GENERAL	5.06		0	44.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,116,658					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: 14-0258

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

Worksheet A-8-1

Date/Time Prepared: 11/30/2017 11:23 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAI MED HOME OFFICE COSTS:					
1.00	5.06	ADMINISTRATIVE AND GENERAL	ABHN & ABHS NON CAPITAL	43,881,682	68,717,148 1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAPITAL	3,479,344	0 2.00
3.00	5.03	PURCHASING RECEIVING AND STO	LOGISTICS	4,776,427	0 3.00
3.01	5.06	ADMINISTRATIVE AND GENERAL	EXECUTIVE SALARIES	1,186,766	1,186,766 3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	EXECUTIVE BENEFITS	94,789	94,789 3.02
3.03	5.02	DATA PROCESSING	ABHN INFO SERVICES	11,973,847	0 3.03
3.04	1.00	CAP REL COSTS-BLDG & FIXT	ABMP RENT	29,548	0 3.04
3.06	90.04	WOUND CLINIC	ABMP RENT	19,840	59,431 3.06
3.07	5.05	CASHIERING/ACCOUNTS RECEIVAB	ABHN PFS	8,211,519	0 3.07
3.08	7.00	OPERATION OF PLANT	CLINICAL ENGINEERING	7,145,281	0 3.08
3.10	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL INTEREST	1,997,843	7,337,352 3.10
3.11	5.06	ADMINISTRATIVE AND GENERAL	OPERATING INTEREST	634,775	0 3.11
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL RELATED ABHN	4,816,325	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			88,247,986	77,395,486 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	ALEXIAN BROTHERS HOSPITAL NE	100.00	0.00	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: 14-0258

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2017 11:23 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-24,835,466	0		1.00
2.00	3,479,344	9		2.00
3.00	4,776,427	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	11,973,847	0		3.03
3.04	29,548	9		3.04
3.06	-39,591	9		3.06
3.07	8,211,519	0		3.07
3.08	7,145,281	0		3.08
3.10	-5,339,509	11		3.10
3.11	634,775	0		3.11
4.00	4,816,325	9		4.00
5.00	10,852,500			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			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: 14-0258

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2017 11:23 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	183,505	183,505	0	0	0	1.00
2.00	43.00	NURSERY	725,670	725,670	0	0	0	2.00
3.00	50.01	GAMMA KNIFE	61,167	0	61,167	246,400	517	3.00
4.00	60.00	LABORATORY	9,600	0	9,600	260,300	100	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	23,734	23,734	0	0	0	5.00
6.00	70.01	NEUROMEG	0	0	0	0	0	6.00
7.00	90.02	IMAGING CENTERS	0	0	0	0	0	7.00
8.00	90.05	CARDIOVASCULAR IMAGING CENTERS	49,864	49,864	0	0	0	8.00
9.00	91.00	EMERGENCY	257,000	0	257,000	211,500	1,809	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,310,540	982,773	327,767		2,426	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	43.00	NURSERY	0	0	0	0	0	2.00
3.00	50.01	GAMMA KNIFE	61,245	3,062	0	0	0	3.00
4.00	60.00	LABORATORY	12,514	626	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	70.01	NEUROMEG	0	0	0	0	0	6.00
7.00	90.02	IMAGING CENTERS	0	0	0	0	0	7.00
8.00	90.05	CARDIOVASCULAR IMAGING CENTERS	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	183,944	9,197	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			257,703	12,885	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	183,505		1.00
2.00	43.00	NURSERY	0	0	0	725,670		2.00
3.00	50.01	GAMMA KNIFE	0	61,245	0	0		3.00
4.00	60.00	LABORATORY	0	12,514	0	0		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	23,734		5.00
6.00	70.01	NEUROMEG	0	0	0	0		6.00
7.00	90.02	IMAGING CENTERS	0	0	0	0		7.00
8.00	90.05	CARDIOVASCULAR IMAGING CENTERS	0	0	0	49,864		8.00
9.00	91.00	EMERGENCY	0	183,944	73,056	73,056		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	257,703	73,056	1,055,829		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0258

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

Worksheet B
Part I
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	15,603,724	15,603,724			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	9,771,590		9,771,590		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	23,396,393	76,903	0	23,473,296	4.00
5.01 00540	NONPATIENT TELEPHONES	819,449	33,484	0	113,029	965,962 5.01
5.02 00550	DATA PROCESSING	11,973,847	9,873	0	0	77,522 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	6,058,363	0	0	0	15,810 5.03
5.04 00570	ADMINISTRATIVE	2,467,308	90,828	0	342,766	28,051 5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	9,868,030	0	0	208,592	36,721 5.05
5.06 00590	ADMINISTRATIVE AND GENERAL	81,286,167	684,165	6,262,049	791,856	140,256 5.06
6.00 00600	MAINTENANCE & REPAIRS	948,466	42,026	51,927	139,856	32,641 6.00
7.00 00700	OPERATION OF PLANT	12,846,554	3,731,739	62,858	0	3,570 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,300,000	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	5,524,187	86,609	0	0	9,180 9.00
10.00 01000	DIETARY	5,289,053	267,164	23,862	6,970	23,971 10.00
11.00 01100	CAFETERIA	1,036,723	301,459	0	3,945	0 11.00
13.00 01300	NURSING ADMINISTRATION	2,761,712	15,464	4,046	292,345	9,690 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	965,886	335,317	47,225	128,133	6,120 14.00
15.00 01500	PHARMACY	5,379,898	122,650	64,364	751,046	16,830 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	5,025,840	233,951	12,126	530,102	41,311 16.00
17.00 01700	SOCIAL SERVICE	2,774,644	16,170	0	419,165	6,120 17.00
23.00 02300	PARAMED PRGM-(SPECIFY)	425,421	19,184	0	60,556	8,160 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRIC CS	37,743,928	2,815,952	96,012	5,409,450	90,782 30.00
31.00 03100	INTENSIVE CARE UNIT	10,134,906	569,642	18,023	1,526,911	30,091 31.00
40.00 04000	SUBPROVIDER - I/PF	2,267,046	289,716	0	299,312	0 40.00
41.00 04100	SUBPROVIDER - I/RF	19,615,237	906,144	56,948	1,463,707	25,501 41.00
43.00 04300	NURSERY	1,516,540	56,160	33,314	229,532	10,200 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	11,016,994	838,033	637,905	1,328,476	30,091 50.00
50.01 05001	GAMMA KNIFE	2,328,414	76,695	2,381	68,933	510 50.01
50.02 03330	ENDOSCOPY	2,871,157	144,764	30,879	315,648	2,550 50.02
51.00 05100	RECOVERY ROOM	1,642,347	127,472	18,648	248,970	6,630 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,281,676	409,352	17,369	343,136	12,240 52.00
53.00 05300	ANESTHESIOLOGY	184,030	9,457	551,052	0	1,020 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,496,553	183,091	227,678	337,656	55,591 54.00
54.01 03630	ULTRA SOUND	1,177,367	95,235	73,925	178,198	1,020 54.01
54.02 05401	PET SCAN	119,205	29,036	0	18,238	0 54.02
54.03 03480	ONCOLOGY	1,440,774	205,850	256,653	209,282	0 54.03
54.04 03440	MAMMOGRAPHY	1,081,864	123,460	3,576	143,509	0 54.04
56.00 05600	RADIOISOTOPE	450,126	120,342	2,744	64,669	6,630 56.00
57.00 05700	CT SCAN	1,488,103	92,138	115,052	220,601	1,020 57.00
58.00 05800	MRI	1,238,097	137,136	12,716	145,103	9,180 58.00
59.00 05900	CARDIAC CATHETERIZATION	7,219,539	332,968	181,632	705,845	10,200 59.00
60.00 06000	LABORATORY	11,081,418	387,549	201,098	1,080,509	44,371 60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	2,189,695	18,103	4,952	85,433	2,550 63.00
64.00 06400	INTRAVENOUS THERAPY	1,819,165	10,247	6,374	163,322	0 64.00
65.00 06500	RESPIRATORY THERAPY	2,912,948	46,786	19,866	417,572	8,160 65.00
66.00 06600	PHYSICAL THERAPY	530,957	172,761	37,773	129,744	7,650 66.00
66.01 06601	REHAB OUTPATIENT	2,264,252	134,829	2,256	346,127	7,650 66.01
66.02 06602	REHAB MED SURGICAL	2,177,815	17,688	0	332,490	5,610 66.02
69.00 06900	ELECTROCARDIOLOGY	1,059,305	68,755	12,720	127,665	8,160 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	172,314	50,943	13,199	25,352	7,650 70.00
70.01 07001	NEUROMEG	0	0	0	0	0 70.01
70.02 07002	SLEEP LAB	710,862	122,920	4,521	106,777	510 70.02
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,675,107	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	26,693,739	9,353	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	20,738,680	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	527,833	20,036	0	7,701	0 74.00
76.97 07697	CARDIAC REHABILITATION	514,665	87,025	0	76,691	3,570 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,468,022	204,541	24,716	204,749	10,200 90.00
90.01 09001	DAY REHAB	973,719	43,336	537	146,478	510 90.01
90.02 09002	IMAGING CENTERS	1,262,372	0	64,684	126,047	5,100 90.02
90.03 09003	COUMADIN CLINIC	215,176	12,034	0	32,414	510 90.03
90.04 09004	WOUND CLINIC	791,996	126,495	13,646	98,234	1,530 90.04
90.05 09005	CARDIOVASCULAR IMAGING CENTERS	2,048,677	0	347,477	216,316	510 90.05

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0258

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

Worksheet B
Part I
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
91.00	09100	EMERGENCY	6,698,403	299,422	54,682	864,661	50,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	8,186,849	0	0	1,136,249	49,981	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	6,226,111	0	89,380	626,378	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	445,777,238	15,462,452	9,762,845	23,396,446	963,922	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	379,010	44,042	0	26,283	2,040	190.00
191.00	19100	RESEARCH	0	63,123	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,530,935	34,107	8,745	50,567	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	449,687,183	15,603,724	9,771,590	23,473,296	965,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0258

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

Worksheet B
Part I
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal		
		5.02	5.03	5.04	5.05	5A.05		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	NONPATIENT TELEPHONES					5.01	
5.02	00550	DATA PROCESSING	12,061,242				5.02	
5.03	00560	PURCHASING RECEIVING AND STORES	376,311	6,450,484			5.03	
5.04	00570	ADMINITTING	0	2,170	2,931,123		5.04	
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	9,166,544	1,753	0	19,281,640	5.05	
5.06	00590	ADMINISTRATIVE AND GENERAL	2,518,387	18,927	0	91,701,807	5.06	
6.00	00600	MAINTENANCE & REPAIRS	0	218	0	1,215,134	6.00	
7.00	00700	OPERATION OF PLANT	0	176	0	16,644,897	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	1,300,000	8.00	
9.00	00900	HOUSEKEEPING	0	28,775	0	5,648,751	9.00	
10.00	01000	DIETARY	0	8,363	0	5,619,383	10.00	
11.00	01100	CAFETERIA	0	0	0	1,342,127	11.00	
13.00	01300	NURSING ADMINISTRATION	0	0	0	3,083,257	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,400	0	1,487,081	14.00	
15.00	01500	PHARMACY	0	1,472,684	0	7,807,472	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	853	0	5,844,183	16.00	
17.00	01700	SOCIAL SERVICE	0	1,415	0	3,217,514	17.00	
23.00	02300	PARAMED PRGM-(SPECIFY)	0	1,268	0	514,589	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	29,083	249,872	1,643,674	48,078,753	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,728	63,970	420,800	12,770,071	31.00
40.00	04000	SUBPROVIDER - I/PF	0	1,252	16,331	107,426	2,981,083	40.00
41.00	04100	SUBPROVIDER - I/RF	0	22,089	66,473	437,264	22,593,363	41.00
43.00	04300	NURSERY	0	1,771	13,726	90,291	1,951,534	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	226,712	1,491,326	15,569,537	50.00
50.01	05001	GAMMA KNIFE	0	121	19,072	125,455	2,621,581	50.01
50.02	03330	ENDOSCOPY	0	3,911	89,758	590,433	4,049,100	50.02
51.00	05100	RECOVERY ROOM	0	537	34,244	225,262	2,304,110	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,000	16,040	105,510	3,187,323	52.00
53.00	05300	ANESTHESIOLOGY	0	12,182	50,786	334,073	1,142,600	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,190	59,305	390,111	3,752,175	54.00
54.01	03630	ULTRA SOUND	0	298	41,171	270,826	1,838,040	54.01
54.02	05401	PET SCAN	0	78	16,703	109,870	293,130	54.02
54.03	03480	ONCOLOGY	0	2,466	69,851	459,483	2,644,359	54.03
54.04	03440	MAMMOGRAPHY	0	647	21,630	142,284	1,516,970	54.04
56.00	05600	RADIOISOTOPE	0	353	31,858	209,565	886,287	56.00
57.00	05700	CT SCAN	0	1,075	141,754	932,468	2,992,211	57.00
58.00	05800	MRI	0	432	56,670	372,780	1,972,114	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	114,221	166,495	1,095,216	9,826,116	59.00
60.00	06000	LABORATORY	0	419,302	351,491	2,312,644	15,878,382	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	101,392	13,138	86,423	2,501,686	63.00
64.00	06400	INTRAVENOUS THERAPY	0	665	4,335	28,514	2,032,622	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,892	74,478	489,922	3,977,624	65.00
66.00	06600	PHYSICAL THERAPY	0	73	48,978	322,181	1,250,117	66.00
66.01	06601	REHAB OUTPATIENT	0	783	19,813	130,334	2,906,044	66.01
66.02	06602	REHAB MED SURGICAL	0	107	25,691	168,996	2,728,397	66.02
69.00	06900	ELECTROCARDIOLOGY	0	15,212	67,215	442,143	1,801,175	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11	5,508	36,229	311,206	70.00
70.01	07001	NEUROMEG	0	0	0	0	0	70.01
70.02	07002	SLEEP LAB	0	443	15,233	100,206	1,061,472	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,176,031	190,902	1,255,765	34,297,805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,925,846	72,967	479,984	29,181,889	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	248,768	1,636,413	22,623,861	73.00
74.00	07400	RENAL DIALYSIS	0	128	9,153	60,212	625,063	74.00
76.97	07697	CARDIAC REHABILITATION	0	471	2,872	18,894	704,188	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,425	16,394	107,841	2,041,888	90.00
90.01	09001	DAY REHAB	0	300	11,524	75,808	1,252,212	90.01
90.02	09002	IMAGING CENTERS	0	1,094	23,988	157,794	1,641,079	90.02
90.03	09003	COUMADIN CLINIC	0	333	1,944	12,789	275,200	90.03
90.04	09004	WOUND CLINIC	0	9,443	25,927	170,548	1,237,819	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	17,521	73,157	481,234	3,184,892	90.05
91.00	09100	EMERGENCY	0	6,576	175,226	1,152,649	9,302,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0258

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
101.00	10100	HOME HEALTH AGENCY	0	4,826	0	0	9,377,905	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	12,528	0	0	6,954,397	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,061,242	6,447,838	2,931,123	19,281,640	445,545,685	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,077	0	0	453,452	190.00
191.00	19100	RESEARCH	0	0	0	0	63,123	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	569	0	0	3,624,923	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,061,242	6,450,484	2,931,123	19,281,640	449,687,183	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE AND GENERAL	91,701,807					5.06
6.00	00600	MAINTENANCE & REPAIRS	311,270	1,526,404				6.00
7.00	00700	OPERATION OF PLANT	4,263,773	388,380	21,297,050			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	333,009	0	0	1,633,009		8.00
9.00	00900	HOUSEKEEPING	1,446,990	9,014	168,685	0	7,273,440	9.00
10.00	01000	DIETARY	1,439,467	27,805	520,345	0	179,129	10.00
11.00	01100	CAFETERIA	343,801	31,374	587,139	0	202,122	11.00
13.00	01300	NURSING ADMINISTRATION	789,810	1,609	30,118	0	10,368	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	380,932	34,898	653,082	0	224,824	14.00
15.00	01500	PHARMACY	1,999,970	12,765	238,879	0	82,234	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,497,052	24,348	455,656	0	156,860	16.00
17.00	01700	SOCIAL SERVICE	824,202	1,683	31,494	0	10,842	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	131,818	1,997	37,364	0	12,863	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,315,813	293,069	5,484,507	782,394	1,888,040	30.00
31.00	03100	INTENSIVE CARE UNIT	3,271,194	59,285	1,109,467	68,181	381,934	31.00
40.00	04000	SUBPROVIDER - IPF	763,637	30,152	564,267	62,182	194,249	40.00
41.00	04100	SUBPROVIDER - IRF	5,787,538	94,307	1,764,857	222,053	607,552	41.00
43.00	04300	NURSERY	499,907	5,845	109,380	0	37,654	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,988,308	87,218	1,632,200	176,187	561,885	50.00
50.01	05001	GAMMA KNIFE	671,547	7,982	149,375	0	51,422	50.01
50.02	03330	ENDOSCOPY	1,037,222	15,066	281,951	60,428	97,062	50.02
51.00	05100	RECOVERY ROOM	590,223	13,267	248,271	31,114	85,467	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	816,468	42,603	797,276	51,419	274,462	52.00
53.00	05300	ANESTHESIOLOGY	292,690	984	18,419	0	6,341	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	961,161	19,055	356,598	0	122,759	54.00
54.01	03630	ULTRA SOUND	470,834	9,912	185,485	35,338	63,853	54.01
54.02	05401	PET SCAN	75,088	3,022	56,552	0	19,468	54.02
54.03	03480	ONCOLOGY	677,382	21,424	400,925	0	138,019	54.03
54.04	03440	MAMMOGRAPHY	388,589	12,849	240,458	0	82,778	54.04
56.00	05600	RADIOISOTOPE	227,032	12,525	234,386	0	80,687	56.00
57.00	05700	CT SCAN	766,488	9,589	179,453	0	61,777	57.00
58.00	05800	MRI	505,179	14,272	267,095	0	91,947	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,517,068	34,654	648,508	0	223,249	59.00
60.00	06000	LABORATORY	4,067,422	40,334	754,811	0	259,844	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	640,834	1,884	35,259	0	12,138	63.00
64.00	06400	INTRAVENOUS THERAPY	520,678	1,066	19,957	0	6,870	64.00
65.00	06500	RESPIRATORY THERAPY	1,018,912	4,869	91,123	0	31,369	65.00
66.00	06600	PHYSICAL THERAPY	320,231	17,980	336,479	0	115,833	66.00
66.01	06601	REHAB OUTPATIENT	744,415	14,032	262,601	0	90,400	66.01
66.02	06602	REHAB MED SURGICAL	698,909	1,841	34,449	0	11,859	66.02
69.00	06900	ELECTROCARDIOLOGY	461,391	7,156	133,912	0	46,099	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,719	5,302	99,219	0	34,156	70.00
70.01	07001	NEUROMEG	0	0	0	0	0	70.01
70.02	07002	SLEEP LAB	271,908	12,793	239,405	0	82,415	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,785,760	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,475,262	973	18,217	0	6,271	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,795,351	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	160,117	2,085	39,024	0	13,434	74.00
76.97	07697	CARDIAC REHABILITATION	180,386	9,057	169,495	0	58,349	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	523,052	21,287	398,375	0	137,141	90.00
90.01	09001	DAY REHAB	320,768	4,510	84,403	0	29,056	90.01
90.02	09002	IMAGING CENTERS	420,380	0	0	0	0	90.02
90.03	09003	COUMADIN CLINIC	70,496	1,252	23,439	0	8,069	90.03
90.04	09004	WOUND CLINIC	317,081	13,165	246,368	0	84,812	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	815,845	0	0	0	0	90.05
91.00	09100	EMERGENCY	2,382,838	31,162	583,171	143,713	200,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	2,402,254	0	0	0	0	101.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0258			Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description		ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.06	6.00	7.00	8.00	9.00		
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,781,445	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,640,916	1,511,701	21,021,899	1,633,009	7,178,719	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	116,157	4,584	85,780	0	29,530	190.00
191.00	19100	RESEARCH	16,170	6,569	122,941	0	42,323	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	928,564	3,550	66,430	0	22,868	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	91,701,807	1,526,404	21,297,050	1,633,009	7,273,440	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	7,786,129					10.00
11.00	01100	CAFETERIA	0	2,506,563				11.00
13.00	01300	NURSING ADMINISTRATION	0	22,993	3,938,155			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,687	0	2,809,504		14.00
15.00	01500	PHARMACY	0	75,081	0	0	10,216,401	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	82,929	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	38,734	0	0	0	17.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	12,246	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,954,452	702,007	1,788,196	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	750,114	169,252	431,127	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	422,606	48,695	124,038	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	1,658,957	203,093	517,330	0	0	41.00
43.00	04300	NURSERY	0	26,488	67,471	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	153,685	391,475	0	0	50.00
50.01	05001	GAMMA KNIFE	0	4,456	11,350	0	0	50.01
50.02	03330	ENDOSCOPY	0	37,526	95,588	0	0	50.02
51.00	05100	RECOVERY ROOM	0	22,804	58,087	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,064	104,601	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,641	0	0	0	54.00
54.01	03630	ULTRASOUND	0	16,164	0	0	0	54.01
54.02	05401	PET SCAN	0	1,791	0	0	0	54.02
54.03	03480	ONCOLOGY	0	18,756	0	0	0	54.03
54.04	03440	MAMMOGRAPHY	0	16,688	0	0	0	54.04
56.00	05600	RADIOISOTOPE	0	5,927	0	0	0	56.00
57.00	05700	CT SCAN	0	23,736	0	0	0	57.00
58.00	05800	MRI	0	14,285	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	62,543	0	0	0	59.00
60.00	06000	LABORATORY	0	186,420	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	10,455	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	15,042	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	55,247	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,999	0	0	0	66.00
66.01	06601	REHAB OUTPATIENT	0	39,521	0	0	0	66.01
66.02	06602	REHAB MED SURGICAL	0	35,997	0	0	0	66.02
69.00	06900	ELECTROCARDIOLOGY	0	15,770	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,378	0	0	0	70.00
70.01	07001	NEUROMEG	0	0	0	0	0	70.01
70.02	07002	SLEEP LAB	0	16,484	0	0	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,401,821	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,398,218	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,216,401	73.00
74.00	07400	RENAL DIALYSIS	0	684	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	9,057	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	22,877	58,272	0	0	90.00
90.01	09001	DAY REHAB	0	17,416	0	0	0	90.01
90.02	09002	IMAGING CENTERS	0	15,523	0	0	0	90.02
90.03	09003	COUMADIN CLINIC	0	3,437	0	0	0	90.03
90.04	09004	WOUND CLINIC	0	15,144	0	0	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	26,459	0	0	0	90.05
91.00	09100	EMERGENCY	0	114,092	290,620	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0258

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

Worksheet B
Part I
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
101.00	10100 HOME HEALTH AGENCY	0	0	0	6,550	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	0	0	0	2,678	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	7,786,129	2,497,273	3,938,155	2,809,267	10,216,401	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,048	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	5,242	0	237	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	7,786,129	2,506,563	3,938,155	2,809,504	10,216,401	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
			16.00	17.00	23.00	24.00	25.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE AND GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,061,028				16.00
17.00	01700	SOCIAL SERVICE	0	4,124,469			17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	710,877		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,129,374	2,624,472	452,343	84,493,420	30.00
31.00	03100	INTENSIVE CARE UNIT	776,598	397,351	68,486	20,253,060	31.00
40.00	04000	SUBPROVIDER - I/PF	437,527	223,863	38,584	5,890,883	40.00
41.00	04100	SUBPROVIDER - I/RF	1,717,529	878,783	151,464	36,196,826	41.00
43.00	04300	NURSERY	0	0	0	2,698,279	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	22,560,495	50.00
50.01	05001	GAMMA KNIFE	0	0	0	3,517,713	50.01
50.02	03330	ENDOSCOPY	0	0	0	5,673,943	50.02
51.00	05100	RECOVERY ROOM	0	0	0	3,353,343	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,315,216	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,461,034	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,261,389	54.00
54.01	03630	ULTRA SOUND	0	0	0	2,619,626	54.01
54.02	05401	PET SCAN	0	0	0	449,051	54.02
54.03	03480	ONCOLOGY	0	0	0	3,900,865	54.03
54.04	03440	MAMMOGRAPHY	0	0	0	2,258,332	54.04
56.00	05600	RADIOISOTOPE	0	0	0	1,446,844	56.00
57.00	05700	CT SCAN	0	0	0	4,033,254	57.00
58.00	05800	MRI	0	0	0	2,864,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	13,312,138	59.00
60.00	06000	LABORATORY	0	0	0	21,187,213	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,202,256	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,596,235	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	5,179,144	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,055,639	66.00
66.01	06601	REHAB OUTPATIENT	0	0	0	4,057,013	66.01
66.02	06602	REHAB MED SURGICAL	0	0	0	3,511,452	66.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,465,503	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	532,980	70.00
70.01	07001	NEUROMEG	0	0	0	0	70.01
70.02	07002	SLEEP LAB	0	0	0	1,684,477	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	44,485,386	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,080,830	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,635,613	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	840,407	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,130,532	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	3,202,892	90.00
90.01	09001	DAY REHAB	0	0	0	1,708,365	90.01
90.02	09002	IMAGING CENTERS	0	0	0	2,076,982	90.02
90.03	09003	COUMADIN CLINIC	0	0	0	381,893	90.03
90.04	09004	WOUND CLINIC	0	0	0	1,914,389	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	0	0	4,027,196	90.05
91.00	09100	EMERGENCY	0	0	0	13,048,463	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0258

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

Worksheet B
Part I
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	23.00	24.00	25.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	11,786,709	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	8,738,520	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,061,028	4,124,469	710,877	444,090,692	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	693,551	0	190.00
191.00	19100	RESEARCH	0	0	0	251,126	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	4,651,814	0	192.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,061,028	4,124,469	710,877	449,687,183	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540 NONPATIENT TELEPHONES		5.01
5.02	00550 DATA PROCESSING		5.02
5.03	00560 PURCHASING RECEIVING AND STORES		5.03
5.04	00570 ADMINISTRATION		5.04
5.05	00580 CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00590 ADMINISTRATIVE AND GENERAL		5.06
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	84,493,420	30.00
31.00	03100 INTENSIVE CARE UNIT	20,253,060	31.00
40.00	04000 SUBPROVIDER - IPF	5,890,883	40.00
41.00	04100 SUBPROVIDER - IRF	36,196,826	41.00
43.00	04300 NURSERY	2,698,279	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	22,560,495	50.00
50.01	05001 GAMMA KNIFE	3,517,713	50.01
50.02	03330 ENDOSCOPY	5,673,943	50.02
51.00	05100 RECOVERY ROOM	3,353,343	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,315,216	52.00
53.00	05300 ANESTHESIOLOGY	1,461,034	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,261,389	54.00
54.01	03630 ULTRA SOUND	2,619,626	54.01
54.02	05401 PET SCAN	449,051	54.02
54.03	03480 ONCOLOGY	3,900,865	54.03
54.04	03440 MAMMOGRAPHY	2,258,332	54.04
56.00	05600 RADIOISOTOPE	1,446,844	56.00
57.00	05700 CT SCAN	4,033,254	57.00
58.00	05800 MRI	2,864,892	58.00
59.00	05900 CARDIAC CATHETERIZATION	13,312,138	59.00
60.00	06000 LABORATORY	21,187,213	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3,202,256	63.00
64.00	06400 INTRAVENOUS THERAPY	2,596,235	64.00
65.00	06500 RESPIRATORY THERAPY	5,179,144	65.00
66.00	06600 PHYSICAL THERAPY	2,055,639	66.00
66.01	06601 REHAB OUTPATIENT	4,057,013	66.01
66.02	06602 REHAB MED SURGICAL	3,511,452	66.02
69.00	06900 ELECTROCARDIOLOGY	2,465,503	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	532,980	70.00
70.01	07001 NEUROLOG	0	70.01
70.02	07002 SLEEP LAB	1,684,477	70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	44,485,386	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	38,080,830	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	38,635,613	73.00
74.00	07400 RENAL DIALYSIS	840,407	74.00
76.97	07697 CARDIAC REHABILITATION	1,130,532	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699 LI THOTRI PSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	3,202,892	90.00
90.01	09001 DAY REHAB	1,708,365	90.01
90.02	09002 IMAGING CENTERS	2,076,982	90.02
90.03	09003 COUMADIN CLINIC	381,893	90.03
90.04	09004 WOUND CLINIC	1,914,389	90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	4,027,196	90.05
91.00	09100 EMERGENCY	13,048,463	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0	94.00
101.00	10100 HOME HEALTH AGENCY	11,786,709	101.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0258

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

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Cost Center Description		Total	
		26.00	
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	8,738,520	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	444,090,692	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	693,551	190.00
191.00	19100 RESEARCH	251,126	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4,651,814	192.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	449,687,183	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	76,903	0	76,903	4.00
5.01 00540	NONPATIENT TELEPHONES	0	33,484	0	33,484	5.01
5.02 00550	DATA PROCESSING	0	9,873	0	9,873	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	0	0	0	5.03
5.04 00570	ADMINISTRATIVE	0	90,828	0	90,828	5.04
5.05 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	5.05
5.06 00590	ADMINISTRATIVE AND GENERAL	0	684,165	6,262,049	6,946,214	5.06
6.00 00600	MAINTENANCE & REPAIRS	0	42,026	51,927	93,953	6.00
7.00 00700	OPERATION OF PLANT	0	3,731,739	62,858	3,794,597	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	86,609	0	86,609	9.00
10.00 01000	DIETARY	0	267,164	23,862	291,026	10.00
11.00 01100	CAFETERIA	0	301,459	0	301,459	11.00
13.00 01300	NURSING ADMINISTRATION	0	15,464	4,046	19,510	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	335,317	47,225	382,542	14.00
15.00 01500	PHARMACY	0	122,650	64,364	187,014	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	233,951	12,126	246,077	16.00
17.00 01700	SOCIAL SERVICE	0	16,170	0	16,170	17.00
23.00 02300	PARAMEDICAL PRGM - (SPECIFY)	0	19,184	0	19,184	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	2,815,952	96,012	2,911,964	30.00
31.00 03100	INTENSIVE CARE UNIT	0	569,642	18,023	587,665	31.00
40.00 04000	SUBPROVIDER - IPF	0	289,716	0	289,716	40.00
41.00 04100	SUBPROVIDER - IRF	0	906,144	56,948	963,092	41.00
43.00 04300	NURSERY	0	56,160	33,314	89,474	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	838,033	637,905	1,475,938	50.00
50.01 05001	GAMMA KNIFE	0	76,695	2,381	79,076	50.01
50.02 03330	ENDOSCOPY	0	144,764	30,879	175,643	50.02
51.00 05100	RECOVERY ROOM	0	127,472	18,648	146,120	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	409,352	17,369	426,721	52.00
53.00 05300	ANESTHESIOLOGY	0	9,457	551,052	560,509	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	183,091	227,678	410,769	54.00
54.01 03630	ULTRASOUND	0	95,235	73,925	169,160	54.01
54.02 05401	PET SCAN	0	29,036	0	29,036	54.02
54.03 03480	ONCOLOGY	0	205,850	256,653	462,503	54.03
54.04 03440	MAMMOGRAPHY	0	123,460	3,576	127,036	54.04
56.00 05600	RADIOLOGY-SOFT TISSUE	0	120,342	2,744	123,086	56.00
57.00 05700	CT SCAN	0	92,138	115,052	207,190	57.00
58.00 05800	MRI	0	137,136	12,716	149,852	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	332,968	181,632	514,600	59.00
60.00 06000	LABORATORY	0	387,549	201,098	588,647	60.00
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	18,103	4,952	23,055	63.00
64.00 06400	INTRAVENOUS THERAPY	0	10,247	6,374	16,621	64.00
65.00 06500	RESPIRATORY THERAPY	0	46,786	19,866	66,652	65.00
66.00 06600	PHYSICAL THERAPY	0	172,761	37,773	210,534	66.00
66.01 06601	REHAB OUTPATIENT	0	134,829	2,256	137,085	66.01
66.02 06602	REHAB MED SURGICAL	0	17,688	0	17,688	66.02
69.00 06900	ELECTROCARDIOLOGY	0	68,755	12,720	81,475	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	50,943	13,199	64,142	70.00
70.01 07001	NEUROLOGY	0	0	0	0	70.01
70.02 07002	SLEEP LAB	0	122,920	4,521	127,441	70.02
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,353	0	9,353	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	20,036	0	20,036	74.00
76.97 07697	CARDIAC REHABILITATION	0	87,025	0	87,025	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHIOTHERAPY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	204,541	24,716	229,257	90.00
90.01 09001	DAY REHAB	0	43,336	537	43,873	90.01
90.02 09002	IMAGING CENTERS	0	0	64,684	64,684	90.02
90.03 09003	COUMADIN CLINIC	0	12,034	0	12,034	90.03
90.04 09004	WOUND CLINIC	0	126,495	13,646	140,141	90.04
90.05 09005	CARDIOVASCULAR IMAGING CENTERS	0	0	347,477	347,477	90.05
91.00 09100	EMERGENCY	0	299,422	54,682	354,104	91.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0258

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

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0	1.00	2.00	0		92.00
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	3,721	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPICE	0	0	89,380	89,380	2,052	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	15,462,452	9,762,845	25,225,297	76,651	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	44,042	0	44,042	86	190.00
191.00 19100 RESEARCH	0	63,123	0	63,123	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	34,107	8,745	42,852	166	192.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	15,603,724	9,771,590	25,375,314	76,903	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	33,854					5.01
5.02	00550	DATA PROCESSING	2,717	12,590				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	554	393	947			5.03
5.04	00570	ADMINISTRATIVE	983	0	0	92,934		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,287	9,568	0	0	11,538	5.05
5.06	00590	ADMINISTRATIVE AND GENERAL	4,915	2,629	3	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	1,144	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	125	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	322	0	4	0	0	9.00
10.00	01000	DIETARY	840	0	1	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	214	0	1	0	0	14.00
15.00	01500	PHARMACY	590	0	225	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,448	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	214	0	0	0	0	17.00
23.00	02300	PARAMED PRGM-(SPECIFY)	286	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,182	0	4	7,984	907	30.00
31.00	03100	INTENSIVE CARE UNIT	1,055	0	1	2,044	232	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	522	59	40.00
41.00	04100	SUBPROVIDER - I/RF	894	0	3	2,124	241	41.00
43.00	04300	NURSERY	357	0	0	439	50	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,055	0	0	7,244	823	50.00
50.01	05001	GAMMA KNIFE	18	0	0	609	69	50.01
50.02	03330	ENDOSCOPY	89	0	1	2,868	326	50.02
51.00	05100	RECOVERY ROOM	232	0	0	1,094	124	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	429	0	0	513	58	52.00
53.00	05300	ANESTHESIOLOGY	36	0	2	1,623	184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,948	0	0	1,895	215	54.00
54.01	03630	ULTRA SOUND	36	0	0	1,316	149	54.01
54.02	05401	PET SCAN	0	0	0	534	61	54.02
54.03	03480	ONCOLOGY	0	0	0	2,232	254	54.03
54.04	03440	MAMMOGRAPHY	0	0	0	691	79	54.04
56.00	05600	RADIOISOTOPE	232	0	0	1,018	116	56.00
57.00	05700	CT SCAN	36	0	0	4,530	515	57.00
58.00	05800	MRI	322	0	0	1,811	206	58.00
59.00	05900	CARDIAC CATHETERIZATION	357	0	17	5,320	605	59.00
60.00	06000	LABORATORY	1,555	0	64	10,504	2,173	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	89	0	15	420	48	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	139	16	64.00
65.00	06500	RESPIRATORY THERAPY	286	0	1	2,380	270	65.00
66.00	06600	PHYSICAL THERAPY	268	0	0	1,565	178	66.00
66.01	06601	REHAB OUTPATIENT	268	0	0	633	72	66.01
66.02	06602	REHAB MED SURGICAL	197	0	0	821	93	66.02
69.00	06900	ELECTROCARDIOLOGY	286	0	2	2,148	244	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	268	0	0	176	20	70.00
70.01	07001	NEUROMEG	0	0	0	0	0	70.01
70.02	07002	SLEEP LAB	18	0	0	487	55	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	300	6,100	693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	294	2,332	265	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,949	903	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	292	33	74.00
76.97	07697	CARDIAC REHABILITATION	125	0	0	92	10	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	357	0	1	524	60	90.00
90.01	09001	DAY REHAB	18	0	0	368	42	90.01
90.02	09002	IMAGING CENTERS	179	0	0	766	87	90.02
90.03	09003	COUMADIN CLINIC	18	0	0	62	7	90.03
90.04	09004	WOUND CLINIC	54	0	1	828	94	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	18	0	3	2,338	266	90.05
91.00	09100	EMERGENCY	1,770	0	1	5,599	636	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0258

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

Worksheet B
Part II
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMINISTRATIVE	CASHIERING/AC COUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
101.00	10100	HOME HEALTH AGENCY	1,752	0	1	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	2	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,783	12,590	947	92,934	11,538	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	71	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	33,854	12,590	947	92,934	11,538	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE AND GENERAL	6,956,355					5.06
6.00	00600	MAINTENANCE & REPAIRS	23,612	119,167				6.00
7.00	00700	OPERATION OF PLANT	323,444	30,318	4,148,484			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,262	0	0	25,262		8.00
9.00	00900	HOUSEKEEPING	109,767	704	32,858	0	230,264	9.00
10.00	01000	DIETARY	109,196	2,171	101,359	0	5,671	10.00
11.00	01100	CAFETERIA	26,080	2,449	114,370	0	6,399	11.00
13.00	01300	NURSING ADMINISTRATION	59,914	126	5,867	0	328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	28,897	2,724	127,215	0	7,118	14.00
15.00	01500	PHARMACY	151,715	997	46,532	0	2,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	113,564	1,901	88,758	0	4,966	16.00
17.00	01700	SOCIAL SERVICE	62,523	131	6,135	0	343	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	9,999	156	7,278	0	407	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	934,251	22,880	1,068,335	12,103	59,773	30.00
31.00	03100	INTENSIVE CARE UNIT	248,148	4,628	216,115	1,055	12,091	31.00
40.00	04000	SUBPROVIDER - IPF	57,928	2,354	109,914	962	6,150	40.00
41.00	04100	SUBPROVIDER - IRF	439,034	7,363	343,779	3,435	19,234	41.00
43.00	04300	NURSERY	37,922	456	21,306	0	1,192	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	302,547	6,809	317,939	2,726	17,788	50.00
50.01	05001	GAMMA KNIFE	50,943	623	29,097	0	1,628	50.01
50.02	03330	ENDOSCOPY	78,682	1,176	54,922	935	3,073	50.02
51.00	05100	RECOVERY ROOM	44,773	1,036	48,361	481	2,706	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	61,936	3,326	155,303	795	8,689	52.00
53.00	05300	ANESTHESIOLOGY	22,203	77	3,588	0	201	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	72,912	1,488	69,462	0	3,886	54.00
54.01	03630	ULTRA SOUND	35,717	774	36,131	547	2,021	54.01
54.02	05401	PET SCAN	5,696	236	11,016	0	616	54.02
54.03	03480	ONCOLOGY	51,385	1,673	78,097	0	4,369	54.03
54.04	03440	MAMMOGRAPHY	29,478	1,003	46,839	0	2,621	54.04
56.00	05600	RADIOISOTOPE	17,222	978	45,656	0	2,554	56.00
57.00	05700	CT SCAN	58,145	749	34,956	0	1,956	57.00
58.00	05800	MRI	38,322	1,114	52,028	0	2,911	58.00
59.00	05900	CARDIAC CATHETERIZATION	190,941	2,705	126,324	0	7,068	59.00
60.00	06000	LABORATORY	308,549	3,149	147,031	0	8,226	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	48,613	147	6,868	0	384	63.00
64.00	06400	INTRAVENOUS THERAPY	39,498	83	3,887	0	218	64.00
65.00	06500	RESPIRATORY THERAPY	77,293	380	17,750	0	993	65.00
66.00	06600	PHYSICAL THERAPY	24,292	1,404	65,543	0	3,667	66.00
66.01	06601	REHAB OUTPATIENT	56,470	1,096	51,152	0	2,862	66.01
66.02	06602	REHAB MED SURGICAL	53,018	144	6,710	0	375	66.02
69.00	06900	ELECTROCARDIOLOGY	35,000	559	26,085	0	1,459	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,047	414	19,327	0	1,081	70.00
70.01	07001	NEUROMEG	0	0	0	0	0	70.01
70.02	07002	SLEEP LAB	20,627	999	46,634	0	2,609	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	666,475	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	567,062	76	3,548	0	199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	439,627	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	12,146	163	7,602	0	425	74.00
76.97	07697	CARDIAC REHABILITATION	13,684	707	33,016	0	1,847	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	39,678	1,662	77,600	0	4,342	90.00
90.01	09001	DAY REHAB	24,333	352	16,441	0	920	90.01
90.02	09002	IMAGING CENTERS	31,889	0	0	0	0	90.02
90.03	09003	COUMADIN CLINIC	5,348	98	4,566	0	255	90.03
90.04	09004	WOUND CLINIC	24,053	1,028	47,990	0	2,685	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	61,889	0	0	0	0	90.05
91.00	09100	EMERGENCY	180,759	2,433	113,597	2,223	6,356	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	182,231	0	0	0	0	101.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description		ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.06	6.00	7.00	8.00	9.00	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	135,138	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,875,877	118,019	4,094,887	25,262	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,811	358	16,709	0	190.00
191.00	19100	RESEARCH	1,227	513	23,948	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	70,440	277	12,940	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,956,355	119,167	4,148,484	25,262	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMINITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	ADMINISTRATIVE AND GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	510,287					10.00
11.00	01100	CAFETERIA	0	450,770				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,135	91,177			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	5,159	0	554,290		14.00
15.00	01500	PHARMACY	0	13,502	0	0	405,638	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,914	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,966	0	0	0	17.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	2,202	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	324,704	126,248	41,399	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	49,161	30,438	9,982	0	0	31.00
40.00	04000	SUBPROVIDER - I/PF	27,697	8,757	2,872	0	0	40.00
41.00	04100	SUBPROVIDER - I/RF	108,725	36,523	11,977	0	0	41.00
43.00	04300	NURSERY	0	4,763	1,562	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	27,638	9,064	0	0	50.00
50.01	05001	GAMMA KNIFE	0	801	263	0	0	50.01
50.02	03330	ENDOSCOPY	0	6,748	2,213	0	0	50.02
51.00	05100	RECOVERY ROOM	0	4,101	1,345	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,385	2,422	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,927	0	0	0	54.00
54.01	03630	ULTRASOUND	0	2,907	0	0	0	54.01
54.02	05401	PET SCAN	0	322	0	0	0	54.02
54.03	03480	ONCOLOGY	0	3,373	0	0	0	54.03
54.04	03440	MAMMOGRAPHY	0	3,001	0	0	0	54.04
56.00	05600	RADIOISOTOPE	0	1,066	0	0	0	56.00
57.00	05700	CT SCAN	0	4,269	0	0	0	57.00
58.00	05800	MRI	0	2,569	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	11,247	0	0	0	59.00
60.00	06000	LABORATORY	0	33,525	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,880	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	2,705	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,935	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,697	0	0	0	66.00
66.01	06601	REHAB OUTPATIENT	0	7,107	0	0	0	66.01
66.02	06602	REHAB MED SURGICAL	0	6,474	0	0	0	66.02
69.00	06900	ELECTROCARDIOLOGY	0	2,836	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	608	0	0	0	70.00
70.01	07001	NEUROMEG	0	0	0	0	0	70.01
70.02	07002	SLEEP LAB	0	2,964	0	0	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	276,570	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	275,853	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	405,638	73.00
74.00	07400	RENAL DIALYSIS	0	123	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	1,629	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,114	1,349	0	0	90.00
90.01	09001	DAY REHAB	0	3,132	0	0	0	90.01
90.02	09002	IMAGING CENTERS	0	2,792	0	0	0	90.02
90.03	09003	COUMADIN CLINIC	0	618	0	0	0	90.03
90.04	09004	WOUND CLINIC	0	2,723	0	0	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	4,758	0	0	0	90.05
91.00	09100	EMERGENCY	0	20,518	6,729	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0258

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

Worksheet B
Part II
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		DI ETARY	CAFETERIA	NURSING ADM INI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
101.00	10100 HOME HEALTH AGENCY	0	0	0	1,292	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPICE	0	0	0	528	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	510,287	449,099	91,177	554,243	405,638	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	728	0	0	0	190.00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	943	0	47	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	510,287	450,770	91,177	554,290	405,638	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am		
Cost Center	Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00570	ADMITTING					5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06	00590	ADMINISTRATIVE AND GENERAL					5.06
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	473,364				16.00
17.00	01700	SOCIAL SERVICE	0	93,855			17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	39,710		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	301,209	59,722		5,892,402	30.00
31.00	03100	INTENSIVE CARE UNIT	45,604	9,042		1,222,262	31.00
40.00	04000	SUBPROVIDER - I/PF	25,693	5,094		538,698	40.00
41.00	04100	SUBPROVIDER - I/RF	100,858	19,997		2,062,073	41.00
43.00	04300	NURSERY	0	0		158,273	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0		2,173,922	50.00
50.01	05001	GAMMA KNIFE	0	0		163,353	50.01
50.02	03330	ENDOSCOPY	0	0		327,710	50.02
51.00	05100	RECOVERY ROOM	0	0		251,188	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		668,701	52.00
53.00	05300	ANESTHESIOLOGY	0	0		588,423	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		572,608	54.00
54.01	03630	ULTRA SOUND	0	0		249,342	54.01
54.02	05401	PET SCAN	0	0		47,577	54.02
54.03	03480	ONCOLOGY	0	0		604,571	54.03
54.04	03440	MAMMOGRAPHY	0	0		211,218	54.04
56.00	05600	RADIOISOTOPE	0	0		192,140	56.00
57.00	05700	CT SCAN	0	0		313,069	57.00
58.00	05800	MRI	0	0		249,610	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		861,496	59.00
60.00	06000	LABORATORY	0	0		1,106,962	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		81,799	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		63,702	64.00
65.00	06500	RESPIRATORY THERAPY	0	0		177,308	65.00
66.00	06600	PHYSICAL THERAPY	0	0		310,573	66.00
66.01	06601	REHAB OUTPATIENT	0	0		257,879	66.01
66.02	06602	REHAB MED SURGICAL	0	0		86,609	66.02
69.00	06900	ELECTROCARDIOLOGY	0	0		150,512	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		92,166	70.00
70.01	07001	NEUROMEG	0	0		0	70.01
70.02	07002	SLEEP LAB	0	0		202,184	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		950,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		858,982	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		854,117	73.00
74.00	07400	RENAL DIALYSIS	0	0		40,845	74.00
76.97	07697	CARDIAC REHABILITATION	0	0		138,386	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		0	76.98
76.99	07699	LITHOTRIPSY	0	0		0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0		359,615	90.00
90.01	09001	DAY REHAB	0	0		89,959	90.01
90.02	09002	IMAGING CENTERS	0	0		100,810	90.02
90.03	09003	COUMADIN CLINIC	0	0		23,112	90.03
90.04	09004	WOUND CLINIC	0	0		219,919	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	0		417,457	90.05
91.00	09100	EMERGENCY	0	0		697,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
	16.00	17.00	23.00	24.00	25.00			
OTHER REIMBURSABLE COST CENTERS								
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00	94.00
101.00	10100 HOME HEALTH AGENCY	0	0	188,997	0	0	101.00	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE						113.00	113.00
116.00	11600 HOSPICE	0	0	227,100	0	0	116.00	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	473,364	93,855	0	25,045,324	0	118.00	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	71,740	0	0	190.00	190.00
191.00	19100 RESEARCH	0	0	90,151	0	0	191.00	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	128,389	0	0	192.00	192.00
200.00	Cross Foot Adjustments			39,710	39,710	0	200.00	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00	201.00
202.00	TOTAL (sum lines 118-201)	473,364	93,855	39,710	25,375,314	0	202.00	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00570	ADMINISTRATIVE	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	00590	ADMINISTRATIVE AND GENERAL	5.06
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
50.01	05001	GAMMA KNIFE	50.01
50.02	03330	ENDOSCOPY	50.02
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRA SOUND	54.01
54.02	05401	PET SCAN	54.02
54.03	03480	ONCOLOGY	54.03
54.04	03440	MAMMOGRAPHY	54.04
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
66.01	06601	REHAB OUTPATIENT	66.01
66.02	06602	REHAB MED SURGICAL	66.02
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
70.01	07001	NEUROLOG	70.01
70.02	07002	SLEEP LAB	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	DAY REHAB	90.01
90.02	09002	IMAGING CENTERS	90.02
90.03	09003	COUMADIN CLINIC	90.03
90.04	09004	WOUND CLINIC	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	90.05
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
101.00	10100	HOME HEALTH AGENCY	101.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		Total	
		26.00	
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
116.00	11600 HOSPICE	227,100	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,045,324	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	71,740	190.00
191.00	19100 RESEARCH	90,151	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	128,389	192.00
200.00	Cross Foot Adjustments	39,710	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	25,375,314	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NO OF PHONES)	DATA PROCESSING (DATA PROCESSING)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DEPREX EXP ENSE)				
		1.00	2.00	4.00	5.01	5.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	750,737				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,132,360			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,700	0	141,845,382		4.00
5.01	00540	NONPATIENT TELEPHONES	1,611	0	683,014	1,894	5.01
5.02	00550	DATA PROCESSING	475	0	0	152	10,000
5.03	00560	PURCHASING RECEIVING AND STORES	0	0	0	31	312
5.04	00570	ADMINISTRATIVE	4,370	0	2,071,282	55	0
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	1,260,486	72	7,600
5.06	00590	ADMINISTRATIVE AND GENERAL	32,917	3,929,877	4,785,063	275	2,088
6.00	00600	MAINTENANCE & REPAIRS	2,022	32,588	845,130	64	0
7.00	00700	OPERATION OF PLANT	179,544	39,448	0	7	0
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00	00900	HOUSEKEEPING	4,167	0	0	18	0
10.00	01000	DIETARY	12,854	14,975	42,120	47	0
11.00	01100	CAFETERIA	14,504	0	23,840	0	0
13.00	01300	NURSING ADMINISTRATION	744	2,539	1,766,596	19	0
14.00	01400	CENTRAL SERVICES & SUPPLY	16,133	29,637	774,290	12	0
15.00	01500	PHARMACY	5,901	40,393	4,538,456	33	0
16.00	01600	MEDICAL RECORDS & LIBRARY	11,256	7,610	3,203,325	81	0
17.00	01700	SOCIAL SERVICE	778	0	2,532,951	12	0
23.00	02300	PARAMED PRGM-(SPECIFY)	923	0	365,932	16	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	135,483	60,254	32,688,374	178	0
31.00	03100	INTENSIVE CARE UNIT	27,407	11,311	9,226,882	59	0
40.00	04000	SUBPROVIDER - I/PF	13,939	0	1,808,697	0	0
41.00	04100	SUBPROVIDER - I/PF	43,597	35,739	8,844,951	50	0
43.00	04300	NURSERY	2,702	20,907	1,387,029	20	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	40,320	400,330	8,027,772	59	0
50.01	05001	GAMMA KNIFE	3,690	1,494	416,552	1	0
50.02	03330	ENDOSCOPY	6,965	19,379	1,907,410	5	0
51.00	05100	RECOVERY ROOM	6,133	11,703	1,504,487	13	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	19,695	10,900	2,073,515	24	0
53.00	05300	ANESTHESIOLOGY	455	345,824	0	2	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,809	142,884	2,040,405	109	0
54.01	03630	ULTRA SOUND	4,582	46,393	1,076,823	2	0
54.02	05401	PET SCAN	1,397	0	110,208	0	0
54.03	03480	ONCOLOGY	9,904	161,068	1,264,658	0	0
54.04	03440	MAMMOGRAPHY	5,940	2,244	867,205	0	0
56.00	05600	RADIOISOTOPE	5,790	1,722	390,783	13	0
57.00	05700	CT SCAN	4,433	72,203	1,333,056	2	0
58.00	05800	MRI	6,598	7,980	876,834	18	0
59.00	05900	CARDIAC CATHETERIZATION	16,020	113,987	4,265,312	20	0
60.00	06000	LABORATORY	18,646	126,203	6,529,346	87	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	871	3,108	516,261	5	0
64.00	06400	INTRAVENOUS THERAPY	493	4,000	986,930	0	0
65.00	06500	RESPIRATORY THERAPY	2,251	12,467	2,523,320	16	0
66.00	06600	PHYSICAL THERAPY	8,312	23,705	784,021	15	0
66.01	06601	REHAB OUTPATIENT	6,487	1,416	2,091,593	15	0
66.02	06602	REHAB MED SURGICAL	851	0	2,009,187	11	0
69.00	06900	ELECTROCARDIOLOGY	3,308	7,983	771,460	16	0
70.00	07000	ELECTROENCEPHALOGRAPHY	2,451	8,283	153,197	15	0
70.01	07001	NEUROMEG	0	0	0	0	0
70.02	07002	SLEEP LAB	5,914	2,837	645,238	1	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	450	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	964	0	46,534	0	0
76.97	07697	CARDIAC REHABILITATION	4,187	0	463,430	7	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	9,841	15,511	1,237,269	20	0
90.01	09001	DAY REHAB	2,085	337	885,145	1	0
90.02	09002	IMAGING CENTERS	0	40,594	761,685	10	0
90.03	09003	COUMADIN CLINIC	579	0	195,870	1	0
90.04	09004	WOUND CLINIC	6,086	8,564	593,614	3	0
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	218,066	1,307,164	1	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NO OF PHONES)	DATA PROCESSING (DATA PROCESSING)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DEPREC EXPENSE)				
			1.00	2.00	4.00	5.01	5.02	
91.00	09100	EMERGENCY	14,406	34,317	5,225,010	99	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	0	0	6,866,175	98	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	56,092	3,785,105	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	743,940	6,126,872	141,380,992	1,890	10,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,119	0	158,824	4	0	190.00
191.00	19100	RESEARCH	3,037	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,641	5,488	305,566	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	15,603,724	9,771,590	23,473,296	965,962	12,061,242	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.784541	1.593447	0.165485	510.011616	1,206.124200	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			76,903	33,854	12,590	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000542	17.874340	1.259000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		PURCHASING RECEIVING AND STORES (PURCHASING)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
		5.03	5.04	5.05	5A.06	5.06	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560	89,409,023					5.03
5.04	00570	30,080	2,128,748,650				5.04
5.05	00580	24,294		2,128,748,650			5.05
5.06	00590	262,344			-91,701,807	357,985,376	5.06
6.00	00600	3,021				1,215,134	6.00
7.00	00700	2,436				16,644,897	7.00
8.00	00800					1,300,000	8.00
9.00	00900	398,840				5,648,751	9.00
10.00	01000	115,917				5,619,383	10.00
11.00	01100					1,342,127	11.00
13.00	01300					3,083,257	13.00
14.00	01400	60,994				1,487,081	14.00
15.00	01500	20,412,555				7,807,472	15.00
16.00	01600	11,820				5,844,183	16.00
17.00	01700	19,607				3,217,514	17.00
23.00	02300	17,569				514,589	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	403,120	181,461,004	181,461,004		48,078,753	30.00
31.00	03100	79,396	46,456,134	46,456,134		12,770,071	31.00
40.00	04000	17,359	11,859,752	11,859,752		2,981,083	40.00
41.00	04100	306,175	48,273,813	48,273,813		22,593,363	41.00
43.00	04300	24,543	9,968,102	9,968,102		1,951,534	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	164,641,864	164,641,864		15,569,537	50.00
50.01	05001	1,677	13,850,223	13,850,223		2,621,581	50.01
50.02	03330	54,208	65,183,616	65,183,616		4,049,100	50.02
51.00	05100	7,442	24,868,859	24,868,859		2,304,110	51.00
52.00	05200	27,715	11,648,235	11,648,235		3,187,323	52.00
53.00	05300	168,846	36,881,553	36,881,553		1,142,600	53.00
54.00	05400	30,353	43,068,072	43,068,072		3,752,175	54.00
54.01	03630	4,131	29,899,117	29,899,117		1,838,040	54.01
54.02	05401	1,088	12,129,647	12,129,647		293,130	54.02
54.03	03480	34,187	50,726,763	50,726,763		2,644,359	54.03
54.04	03440	8,967	15,708,073	15,708,073		1,516,970	54.04
56.00	05600	4,888	23,135,902	23,135,902		886,287	56.00
57.00	05700	14,905	102,944,176	102,944,176		2,992,211	57.00
58.00	05800	5,987	41,154,752	41,154,752		1,972,114	58.00
59.00	05900	1,583,189	120,911,467	120,911,467		9,826,116	59.00
60.00	06000	5,811,847	255,377,655	255,377,655		15,878,382	60.00
63.00	06300	1,405,379	9,541,032	9,541,032		2,501,686	63.00
64.00	06400	9,212	3,147,972	3,147,972		2,032,622	64.00
65.00	06500	109,392	54,087,221	54,087,221		3,977,624	65.00
66.00	06600	1,007	35,568,658	35,568,658		1,250,117	66.00
66.01	06601	10,856	14,388,779	14,388,779		2,906,044	66.01
66.02	06602	1,487	18,657,098	18,657,098		2,728,397	66.02
69.00	06900	210,853	48,812,394	48,812,394		1,801,175	69.00
70.00	07000	154	3,999,698	3,999,698		311,206	70.00
70.01	07001	0	0	0		0	70.01
70.02	07002	6,142	11,062,671	11,062,671		1,061,472	70.02
71.00	07100	30,161,766	138,636,056	138,636,056		34,297,805	71.00
72.00	07200	26,693,739	52,990,067	52,990,067		29,181,889	72.00
73.00	07300	0	180,659,396	180,659,396		22,623,861	73.00
74.00	07400	1,781	6,647,336	6,647,336		625,063	74.00
76.97	07697	6,534	2,085,856	2,085,856		704,188	76.97
76.98	07698	0	0	0		0	76.98
76.99	07699	0	0	0		0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	75,193	11,905,629	11,905,629		2,041,888	90.00
90.01	09001	4,163	8,369,203	8,369,203		1,252,212	90.01
90.02	09002	15,165	17,420,374	17,420,374		1,641,079	90.02
90.03	09003	4,617	1,411,853	1,411,853		275,200	90.03
90.04	09004	130,882	18,828,436	18,828,436		1,237,819	90.04
90.05	09005	242,850	53,128,071	53,128,071		3,184,892	90.05
91.00	09100	91,142	127,252,071	127,252,071		9,302,110	91.00
92.00	09200						92.00

COST ALLOCATION - STATISTICAL BASIS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet B-1 Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description	PURCHASING RECEIVING AND STORES (PURCHASING)	ADMITTING (GROSS CHARGES)	CASHIERING/AC COUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)			
	5.03	5.04	5.05	5A.06	5.06			
OTHER REIMBURSABLE COST CENTERS								
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00	
101.00	10100 HOME HEALTH AGENCY	66,891	0	0	0	9,377,905	101.00	
SPECIAL PURPOSE COST CENTERS								
113.00	11300 INTEREST EXPENSE						113.00	
116.00	11600 HOSPICE	173,642	0	0	0	6,954,397	116.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	89,372,347	2,128,748,650	2,128,748,650	-91,701,807	353,843,878	118.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,795	0	0	0	453,452	190.00	
191.00	19100 RESEARCH	0	0	0	0	63,123	191.00	
192.00	19200 PHYSICIANS' PRIVATE OFFICES	7,881	0	0	0	3,624,923	192.00	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers						201.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	6,450,484	2,931,123	19,281,640		91,701,807	202.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.072146	0.001377	0.009058		0.256161	203.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	947	92,934	11,538		6,956,355	204.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000011	0.000044	0.000005		0.019432	205.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600	705,642					6.00
7.00	00700	179,544	526,098				7.00
8.00	00800	0	0	2,241,118			8.00
9.00	00900	4,167	4,167	0	521,931		9.00
10.00	01000	12,854	12,854	0	12,854	100,706	10.00
11.00	01100	14,504	14,504	0	14,504	0	11.00
13.00	01300	744	744	0	744	0	13.00
14.00	01400	16,133	16,133	0	16,133	0	14.00
15.00	01500	5,901	5,901	0	5,901	0	15.00
16.00	01600	11,256	11,256	0	11,256	0	16.00
17.00	01700	778	778	0	778	0	17.00
23.00	02300	923	923	0	923	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	135,483	135,483	1,073,747	135,483	64,081	30.00
31.00	03100	27,407	27,407	93,571	27,407	9,702	31.00
40.00	04000	13,939	13,939	85,338	13,939	5,466	40.00
41.00	04100	43,597	43,597	304,742	43,597	21,457	41.00
43.00	04300	2,702	2,702	0	2,702	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	40,320	40,320	241,796	40,320	0	50.00
50.01	05001	3,690	3,690	0	3,690	0	50.01
50.02	03330	6,965	6,965	82,930	6,965	0	50.02
51.00	05100	6,133	6,133	42,700	6,133	0	51.00
52.00	05200	19,695	19,695	70,567	19,695	0	52.00
53.00	05300	455	455	0	455	0	53.00
54.00	05400	8,809	8,809	0	8,809	0	54.00
54.01	03630	4,582	4,582	48,497	4,582	0	54.01
54.02	05401	1,397	1,397	0	1,397	0	54.02
54.03	03480	9,904	9,904	0	9,904	0	54.03
54.04	03440	5,940	5,940	0	5,940	0	54.04
56.00	05600	5,790	5,790	0	5,790	0	56.00
57.00	05700	4,433	4,433	0	4,433	0	57.00
58.00	05800	6,598	6,598	0	6,598	0	58.00
59.00	05900	16,020	16,020	0	16,020	0	59.00
60.00	06000	18,646	18,646	0	18,646	0	60.00
63.00	06300	871	871	0	871	0	63.00
64.00	06400	493	493	0	493	0	64.00
65.00	06500	2,251	2,251	0	2,251	0	65.00
66.00	06600	8,312	8,312	0	8,312	0	66.00
66.01	06601	6,487	6,487	0	6,487	0	66.01
66.02	06602	851	851	0	851	0	66.02
69.00	06900	3,308	3,308	0	3,308	0	69.00
70.00	07000	2,451	2,451	0	2,451	0	70.00
70.01	07001	0	0	0	0	0	70.01
70.02	07002	5,914	5,914	0	5,914	0	70.02
71.00	07100	0	0	0	0	0	71.00
72.00	07200	450	450	0	450	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	964	964	0	964	0	74.00
76.97	07697	4,187	4,187	0	4,187	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	9,841	9,841	0	9,841	0	90.00
90.01	09001	2,085	2,085	0	2,085	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	579	579	0	579	0	90.03
90.04	09004	6,086	6,086	0	6,086	0	90.04
90.05	09005	0	0	0	0	0	90.05
91.00	09100	14,406	14,406	197,230	14,406	0	91.00
92.00	09200						92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	698,845	519,301	2,241,118	515,134	100,706
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,119	2,119	0	2,119	190.00
191.00	19100	RESEARCH	3,037	3,037	0	3,037	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,641	1,641	0	1,641	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,526,404	21,297,050	1,633,009	7,273,440	7,786,129
203.00		Unit cost multiplier (Wkst. B, Part I)	2.163142	40.481146	0.728658	13.935635	77.315443
204.00		Cost to be allocated (per Wkst. B, Part II)	119,167	4,148,484	25,262	230,264	510,287
205.00		Unit cost multiplier (Wkst. B, Part II)	0.168877	7.885383	0.011272	0.441177	5.067096

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT DA YS)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00570						5.04
5.05	00580						5.05
5.06	00590						5.06
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	172,133					11.00
13.00	01300	1,579	106,171				13.00
14.00	01400	1,970	0	53,637,244			14.00
15.00	01500	5,156	0	0	10,000		15.00
16.00	01600	5,695	0	0	0	100,706	16.00
17.00	01700	2,660	0	0	0	0	17.00
23.00	02300	841	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	48,209	48,209	0	0	64,081	30.00
31.00	03100	11,623	11,623	0	0	9,702	31.00
40.00	04000	3,344	3,344	0	0	5,466	40.00
41.00	04100	13,947	13,947	0	0	21,457	41.00
43.00	04300	1,819	1,819	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	10,554	10,554	0	0	0	50.00
50.01	05001	306	306	0	0	0	50.01
50.02	03330	2,577	2,577	0	0	0	50.02
51.00	05100	1,566	1,566	0	0	0	51.00
52.00	05200	2,820	2,820	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	3,409	0	0	0	0	54.00
54.01	03630	1,110	0	0	0	0	54.01
54.02	05401	123	0	0	0	0	54.02
54.03	03480	1,288	0	0	0	0	54.03
54.04	03440	1,146	0	0	0	0	54.04
56.00	05600	407	0	0	0	0	56.00
57.00	05700	1,630	0	0	0	0	57.00
58.00	05800	981	0	0	0	0	58.00
59.00	05900	4,295	0	0	0	0	59.00
60.00	06000	12,802	0	0	0	0	60.00
63.00	06300	718	0	0	0	0	63.00
64.00	06400	1,033	0	0	0	0	64.00
65.00	06500	3,794	0	0	0	0	65.00
66.00	06600	1,030	0	0	0	0	66.00
66.01	06601	2,714	0	0	0	0	66.01
66.02	06602	2,472	0	0	0	0	66.02
69.00	06900	1,083	0	0	0	0	69.00
70.00	07000	232	0	0	0	0	70.00
70.01	07001	0	0	0	0	0	70.01
70.02	07002	1,132	0	0	0	0	70.02
71.00	07100	0	0	26,762,818	0	0	71.00
72.00	07200	0	0	26,693,739	0	0	72.00
73.00	07300	0	0	0	10,000	0	73.00
74.00	07400	47	0	0	0	0	74.00
76.97	07697	622	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	1,571	1,571	0	0	0	90.00
90.01	09001	1,196	0	0	0	0	90.01
90.02	09002	1,066	0	0	0	0	90.02
90.03	09003	236	0	0	0	0	90.03
90.04	09004	1,040	0	0	0	0	90.04
90.05	09005	1,817	0	0	0	0	90.05
91.00	09100	7,835	7,835	0	0	0	91.00
92.00	09200						92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT DA YS)	
		11.00	13.00	14.00	15.00	16.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
101.00	10100	HOME HEALTH AGENCY	0	0	125,041	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	51,124	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	171,495	106,171	53,632,722	10,000	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	0	0	0	190.00
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	360	0	4,522	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,506,563	3,938,155	2,809,504	10,216,401	8,061,028
203.00		Unit cost multiplier (Wkst. B, Part I)	14.561781	37.092568	0.052380	1,021.640100	80.045161
204.00		Cost to be allocated (per Wkst. B, Part II)	450,770	91,177	554,290	405,638	473,364
205.00		Unit cost multiplier (Wkst. B, Part II)	2.618731	0.858775	0.010334	40.563800	4.700455

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet B-1 Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	PARAMED PRGM (PATIENT DAYS)	
		17.00	23.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00570	ADMITTING		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.05
5.06	00590	ADMINISTRATIVE AND GENERAL		5.06
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	100,706	17.00
23.00	02300	PARAMED PRGM- (SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	64,081	30.00
31.00	03100	INTENSIVE CARE UNIT	9,702	31.00
40.00	04000	SUBPROVIDER - IPF	5,466	40.00
41.00	04100	SUBPROVIDER - IRF	21,457	41.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
50.01	05001	GAMMA KNIFE	0	50.01
50.02	03330	ENDOSCOPY	0	50.02
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	03630	ULTRA SOUND	0	54.01
54.02	05401	PET SCAN	0	54.02
54.03	03480	ONCOLOGY	0	54.03
54.04	03440	MAMMOGRAPHY	0	54.04
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
66.01	06601	REHAB OUTPATIENT	0	66.01
66.02	06602	REHAB MED SURGICAL	0	66.02
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
70.01	07001	NEUROLOG	0	70.01
70.02	07002	SLEEP LAB	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	DAY REHAB	0	90.01
90.02	09002	IMAGING CENTERS	0	90.02
90.03	09003	COUMADIN CLINIC	0	90.03
90.04	09004	WOUND CLINIC	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	90.05
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet B-1

Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	PARAMED PRGM (PATIENT DAYS)	
		17.00	23.00	
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0	0	94.00
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
116.00	11600 HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	100,706	100,706	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.00	19100 RESEARCH	0	0	191.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00	Cross Foot Adjustments			200.00
201.00	Negative Cost Centers			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	4,124,469	710,877	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	40.955544	7.058934	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	93,855	39,710	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.931970	0.394316	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/30/2017 11:23 am
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		84,493,420	0	84,493,420
31.00	03100 INTENSIVE CARE UNIT		20,253,060	0	20,253,060
40.00	04000 SUBPROVIDER - IPF		5,890,883	0	5,890,883
41.00	04100 SUBPROVIDER - IRF		36,196,826	0	36,196,826
43.00	04300 NURSERY		2,698,279	0	2,698,279
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		22,560,495	0	22,560,495
50.01	05001 GAMMA KNIFE		3,517,713	0	3,517,713
50.02	03330 ENDOSCOPY		5,673,943	0	5,673,943
51.00	05100 RECOVERY ROOM		3,353,343	0	3,353,343
52.00	05200 DELIVERY ROOM & LABOR ROOM		5,315,216	0	5,315,216
53.00	05300 ANESTHESIOLOGY		1,461,034	0	1,461,034
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,261,389	0	5,261,389
54.01	03630 ULTRA SOUND		2,619,626	0	2,619,626
54.02	05401 PET SCAN		449,051	0	449,051
54.03	03480 ONCOLOGY		3,900,865	0	3,900,865
54.04	03440 MAMMOGRAPHY		2,258,332	0	2,258,332
56.00	05600 RADIOISOTOPE		1,446,844	0	1,446,844
57.00	05700 CT SCAN		4,033,254	0	4,033,254
58.00	05800 MRI		2,864,892	0	2,864,892
59.00	05900 CARDIAC CATHETERIZATION		13,312,138	0	13,312,138
60.00	06000 LABORATORY		21,187,213	0	21,187,213
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.		3,202,256	0	3,202,256
64.00	06400 INTRAVENOUS THERAPY		2,596,235	0	2,596,235
65.00	06500 RESPIRATORY THERAPY	0	5,179,144	0	5,179,144
66.00	06600 PHYSICAL THERAPY	0	2,055,639	0	2,055,639
66.01	06601 REHAB OUTPATIENT	0	4,057,013	0	4,057,013
66.02	06602 REHAB MED SURGICAL	0	3,511,452	0	3,511,452
69.00	06900 ELECTROCARDIOLOGY		2,465,503	0	2,465,503
70.00	07000 ELECTROENCEPHALOGRAPHY		532,980	0	532,980
70.01	07001 NEUROLOG		0	0	0
70.02	07002 SLEEP LAB		1,684,477	0	1,684,477
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		44,485,386	0	44,485,386
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		38,080,830	0	38,080,830
73.00	07300 DRUGS CHARGED TO PATIENTS		38,635,613	0	38,635,613
74.00	07400 RENAL DIALYSIS		840,407	0	840,407
76.97	07697 CARDIAC REHABILITATION		1,130,532	0	1,130,532
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0
76.99	07699 LI THOTRI PSY		0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		3,202,892	0	3,202,892
90.01	09001 DAY REHAB		1,708,365	0	1,708,365
90.02	09002 IMAGING CENTERS		2,076,982	0	2,076,982
90.03	09003 COUMADIN CLINIC		381,893	0	381,893
90.04	09004 WOUND CLINIC		1,914,389	0	1,914,389
90.05	09005 CARDIOVASCULAR IMAGING CENTERS		4,027,196	0	4,027,196
91.00	09100 EMERGENCY		13,048,463	73,056	13,121,519
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		3,682,354		3,682,354
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS		0	0	0
101.00	10100 HOME HEALTH AGENCY		11,786,709		11,786,709
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
116.00	11600 HOSPICE		8,738,520		8,738,520
200.00	Subtotal (see instructions)		447,773,046	73,056	447,846,102
201.00	Less Observation Beds		3,682,354		3,682,354
202.00	Total (see instructions)		444,090,692	73,056	444,163,748

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/30/2017 11:23 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	174,046,825		174,046,825				30.00
31.00	03100	INTENSIVE CARE UNIT	46,456,134		46,456,134				31.00
40.00	04000	SUBPROVIDER - IPF	11,859,752		11,859,752				40.00
41.00	04100	SUBPROVIDER - IRF	48,273,813		48,273,813				41.00
43.00	04300	NURSERY	9,968,102		9,968,102				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	89,120,944	75,520,920	164,641,864	0.137028	0.000000		50.00
50.01	05001	GAMMA KNIFE	128,950	13,721,273	13,850,223	0.253982	0.000000		50.01
50.02	03330	ENDOSCOPY	11,021,360	54,162,256	65,183,616	0.087046	0.000000		50.02
51.00	05100	RECOVERY ROOM	12,696,029	12,172,829	24,868,858	0.134841	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,636,138	12,097	11,648,235	0.456311	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	19,414,497	17,467,056	36,881,553	0.039614	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,674,838	26,393,234	43,068,072	0.122164	0.000000		54.00
54.01	03630	ULTRA SOUND	10,154,415	19,744,702	29,899,117	0.087615	0.000000		54.01
54.02	05401	PET SCAN	74,498	12,055,149	12,129,647	0.037021	0.000000		54.02
54.03	03480	ONCOLOGY	2,170,319	48,556,444	50,726,763	0.076900	0.000000		54.03
54.04	03440	MAMMOGRAPHY	57,948	15,650,125	15,708,073	0.143769	0.000000		54.04
56.00	05600	RADIOISOTOPE	7,455,885	15,680,017	23,135,902	0.062537	0.000000		56.00
57.00	05700	CT SCAN	34,164,026	68,780,150	102,944,176	0.039179	0.000000		57.00
58.00	05800	MRI	13,178,908	27,975,844	41,154,752	0.069613	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	54,973,232	65,938,235	120,911,467	0.110098	0.000000		59.00
60.00	06000	LABORATORY	106,011,954	149,365,701	255,377,655	0.082964	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,659,188	1,881,844	9,541,032	0.335630	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	2,893,446	254,526	3,147,972	0.824733	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	50,473,769	3,613,452	54,087,221	0.095755	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	35,568,658	0	35,568,658	0.057794	0.000000		66.00
66.01	06601	REHAB OUTPATIENT	3,829	14,384,950	14,388,779	0.281957	0.000000		66.01
66.02	06602	REHAB MED SURGICAL	17,889,361	767,737	18,657,098	0.188210	0.000000		66.02
69.00	06900	ELECTROCARDIOLOGY	24,428,617	24,383,777	48,812,394	0.050510	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	895,328	3,104,370	3,999,698	0.133255	0.000000		70.00
70.01	07001	NEUROMEG	0	0	0	0.000000	0.000000		70.01
70.02	07002	SLEEP LAB	5,595	11,057,076	11,062,671	0.152267	0.000000		70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,626,919	60,009,137	138,636,056	0.320879	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,654,684	17,335,383	52,990,067	0.718641	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,100,002	65,559,394	180,659,396	0.213859	0.000000		73.00
74.00	07400	RENAL DIALYSIS	6,330,248	317,088	6,647,336	0.126428	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	259,626	1,826,230	2,085,856	0.541999	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	436,381	11,469,248	11,905,629	0.269023	0.000000		90.00
90.01	09001	DAY REHAB	1,963	8,367,240	8,369,203	0.204125	0.000000		90.01
90.02	09002	IMAGING CENTERS	120,542	17,299,832	17,420,374	0.119227	0.000000		90.02
90.03	09003	COUMADIN CLINIC	3,410	1,408,443	1,411,853	0.270491	0.000000		90.03
90.04	09004	WOUND CLINIC	70,156	18,758,280	18,828,436	0.101675	0.000000		90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	221,245	52,906,826	53,128,071	0.075802	0.000000		90.05
91.00	09100	EMERGENCY	40,492,341	86,759,730	127,252,071	0.102540	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,414,179	7,414,179	0.496664	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000		94.00
101.00	10100	HOME HEALTH AGENCY	0	10,997,471	10,997,471				101.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	7,744,487	7,744,487				116.00
200.00		Subtotal (see instructions)	1,096,673,875	1,050,816,732	2,147,490,607				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	1,096,673,875	1,050,816,732	2,147,490,607				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/30/2017 11:23 am
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.137028		50.00
50.01	05001	GAMMA KNIFE	0.253982		50.01
50.02	03330	ENDOSCOPY	0.087046		50.02
51.00	05100	RECOVERY ROOM	0.134841		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.456311		52.00
53.00	05300	ANESTHESIOLOGY	0.039614		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122164		54.00
54.01	03630	ULTRA SOUND	0.087615		54.01
54.02	05401	PET SCAN	0.037021		54.02
54.03	03480	ONCOLOGY	0.076900		54.03
54.04	03440	MAMMOGRAPHY	0.143769		54.04
56.00	05600	RADIO SOTOPE	0.062537		56.00
57.00	05700	CT SCAN	0.039179		57.00
58.00	05800	MRI	0.069613		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110098		59.00
60.00	06000	LABORATORY	0.082964		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.335630		63.00
64.00	06400	INTRAVENOUS THERAPY	0.824733		64.00
65.00	06500	RESPIRATORY THERAPY	0.095755		65.00
66.00	06600	PHYSICAL THERAPY	0.057794		66.00
66.01	06601	REHAB OUTPATIENT	0.281957		66.01
66.02	06602	REHAB MED SURGICAL	0.188210		66.02
69.00	06900	ELECTROCARDIOLOGY	0.050510		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.133255		70.00
70.01	07001	NEUROLOG	0.000000		70.01
70.02	07002	SLEEP LAB	0.152267		70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.320879		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718641		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213859		73.00
74.00	07400	RENAL DIALYSIS	0.126428		74.00
76.97	07697	CARDIAC REHABILITATION	0.541999		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.269023		90.00
90.01	09001	DAY REHAB	0.204125		90.01
90.02	09002	IMAGING CENTERS	0.119227		90.02
90.03	09003	COUMADIN CLINIC	0.270491		90.03
90.04	09004	WOUND CLINIC	0.101675		90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0.075802		90.05
91.00	09100	EMERGENCY	0.103114		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.496664		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/30/2017 11:23 am
			Title XIX	Hospital	Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Disallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		84,493,420	0	84,493,420
31.00	03100 INTENSIVE CARE UNIT		20,253,060	0	20,253,060
40.00	04000 SUBPROVIDER - IPF		5,890,883	0	5,890,883
41.00	04100 SUBPROVIDER - IRF		36,196,826	0	36,196,826
43.00	04300 NURSERY		2,698,279	0	2,698,279
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		22,560,495	0	22,560,495
50.01	05001 GAMMA KNIFE		3,517,713	0	3,517,713
50.02	03330 ENDOSCOPY		5,673,943	0	5,673,943
51.00	05100 RECOVERY ROOM		3,353,343	0	3,353,343
52.00	05200 DELIVERY ROOM & LABOR ROOM		5,315,216	0	5,315,216
53.00	05300 ANESTHESIOLOGY		1,461,034	0	1,461,034
54.00	05400 RADIOLOGY-DIAGNOSTIC		5,261,389	0	5,261,389
54.01	03630 ULTRA SOUND		2,619,626	0	2,619,626
54.02	05401 PET SCAN		449,051	0	449,051
54.03	03480 ONCOLOGY		3,900,865	0	3,900,865
54.04	03440 MAMMOGRAPHY		2,258,332	0	2,258,332
56.00	05600 RADIOISOTOPE		1,446,844	0	1,446,844
57.00	05700 CT SCAN		4,033,254	0	4,033,254
58.00	05800 MRI		2,864,892	0	2,864,892
59.00	05900 CARDIAC CATHETERIZATION		13,312,138	0	13,312,138
60.00	06000 LABORATORY		21,187,213	0	21,187,213
63.00	06300 BLOOD STORAGE, PROCESSING & TRANS.		3,202,256	0	3,202,256
64.00	06400 INTRAVENOUS THERAPY		2,596,235	0	2,596,235
65.00	06500 RESPIRATORY THERAPY	0	5,179,144	0	5,179,144
66.00	06600 PHYSICAL THERAPY	0	2,055,639	0	2,055,639
66.01	06601 REHAB OUTPATIENT	0	4,057,013	0	4,057,013
66.02	06602 REHAB MED SURGICAL	0	3,511,452	0	3,511,452
69.00	06900 ELECTROCARDIOLOGY		2,465,503	0	2,465,503
70.00	07000 ELECTROENCEPHALOGRAPHY		532,980	0	532,980
70.01	07001 NEUROLOG		0	0	0
70.02	07002 SLEEP LAB		1,684,477	0	1,684,477
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		44,485,386	0	44,485,386
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		38,080,830	0	38,080,830
73.00	07300 DRUGS CHARGED TO PATIENTS		38,635,613	0	38,635,613
74.00	07400 RENAL DIALYSIS		840,407	0	840,407
76.97	07697 CARDIAC REHABILITATION		1,130,532	0	1,130,532
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0
76.99	07699 LI THOTRI PSY		0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		3,202,892	0	3,202,892
90.01	09001 DAY REHAB		1,708,365	0	1,708,365
90.02	09002 IMAGING CENTERS		2,076,982	0	2,076,982
90.03	09003 COUMADIN CLINIC		381,893	0	381,893
90.04	09004 WOUND CLINIC		1,914,389	0	1,914,389
90.05	09005 CARDIOVASCULAR IMAGING CENTERS		4,027,196	0	4,027,196
91.00	09100 EMERGENCY		13,048,463	73,056	13,121,519
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		3,682,354	0	3,682,354
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS		0	0	0
101.00	10100 HOME HEALTH AGENCY		11,786,709	0	11,786,709
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
116.00	11600 HOSPICE		8,738,520		8,738,520
200.00	Subtotal (see instructions)		447,773,046	73,056	447,846,102
201.00	Less Observation Beds		3,682,354		3,682,354
202.00	Total (see instructions)		444,090,692	73,056	444,163,748

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/30/2017 11:23 am	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	174,046,825		174,046,825			30.00
31.00	03100	INTENSIVE CARE UNIT	46,456,134		46,456,134			31.00
40.00	04000	SUBPROVIDER - IPF	11,859,752		11,859,752			40.00
41.00	04100	SUBPROVIDER - IRF	48,273,813		48,273,813			41.00
43.00	04300	NURSERY	9,968,102		9,968,102			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	89,120,944	75,520,920	164,641,864	0.137028	0.000000	50.00
50.01	05001	GAMMA KNIFE	128,950	13,721,273	13,850,223	0.253982	0.000000	50.01
50.02	03330	ENDOSCOPY	11,021,360	54,162,256	65,183,616	0.087046	0.000000	50.02
51.00	05100	RECOVERY ROOM	12,696,029	12,172,829	24,868,858	0.134841	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,636,138	12,097	11,648,235	0.456311	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	19,414,497	17,467,056	36,881,553	0.039614	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,674,838	26,393,234	43,068,072	0.122164	0.000000	54.00
54.01	03630	ULTRA SOUND	10,154,415	19,744,702	29,899,117	0.087615	0.000000	54.01
54.02	05401	PET SCAN	74,498	12,055,149	12,129,647	0.037021	0.000000	54.02
54.03	03480	ONCOLOGY	2,170,319	48,556,444	50,726,763	0.076900	0.000000	54.03
54.04	03440	MAMMOGRAPHY	57,948	15,650,125	15,708,073	0.143769	0.000000	54.04
56.00	05600	RADIOISOTOPE	7,455,885	15,680,017	23,135,902	0.062537	0.000000	56.00
57.00	05700	CT SCAN	34,164,026	68,780,150	102,944,176	0.039179	0.000000	57.00
58.00	05800	MRI	13,178,908	27,975,844	41,154,752	0.069613	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	54,973,232	65,938,235	120,911,467	0.110098	0.000000	59.00
60.00	06000	LABORATORY	106,011,954	149,365,701	255,377,655	0.082964	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,659,188	1,881,844	9,541,032	0.335630	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,893,446	254,526	3,147,972	0.824733	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	50,473,769	3,613,452	54,087,221	0.095755	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	35,568,658	0	35,568,658	0.057794	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	3,829	14,384,950	14,388,779	0.281957	0.000000	66.01
66.02	06602	REHAB MED SURGICAL	17,889,361	767,737	18,657,098	0.188210	0.000000	66.02
69.00	06900	ELECTROCARDIOLOGY	24,428,617	24,383,777	48,812,394	0.050510	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	895,328	3,104,370	3,999,698	0.133255	0.000000	70.00
70.01	07001	NEUROMEG	0	0	0	0.000000	0.000000	70.01
70.02	07002	SLEEP LAB	5,595	11,057,076	11,062,671	0.152267	0.000000	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	78,626,919	60,009,137	138,636,056	0.320879	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,654,684	17,335,383	52,990,067	0.718641	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	115,100,002	65,559,394	180,659,396	0.213859	0.000000	73.00
74.00	07400	RENAL DIALYSIS	6,330,248	317,088	6,647,336	0.126428	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	259,626	1,826,230	2,085,856	0.541999	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	436,381	11,469,248	11,905,629	0.269023	0.000000	90.00
90.01	09001	DAY REHAB	1,963	8,367,240	8,369,203	0.204125	0.000000	90.01
90.02	09002	IMAGING CENTERS	120,542	17,299,832	17,420,374	0.119227	0.000000	90.02
90.03	09003	COUMADIN CLINIC	3,410	1,408,443	1,411,853	0.270491	0.000000	90.03
90.04	09004	WOUND CLINIC	70,156	18,758,280	18,828,436	0.101675	0.000000	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	221,245	52,906,826	53,128,071	0.075802	0.000000	90.05
91.00	09100	EMERGENCY	40,492,341	86,759,730	127,252,071	0.102540	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,414,179	7,414,179	0.496664	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
101.00	10100	HOME HEALTH AGENCY	0	10,997,471	10,997,471			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	7,744,487	7,744,487			116.00
200.00		Subtotal (see instructions)	1,096,673,875	1,050,816,732	2,147,490,607			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	1,096,673,875	1,050,816,732	2,147,490,607			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/30/2017 11:23 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		Cost
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
50.01	05001	GAMMA KNIFE	0.000000		50.01
50.02	03330	ENDOSCOPY	0.000000		50.02
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
54.02	05401	PET SCAN	0.000000		54.02
54.03	03480	ONCOLOGY	0.000000		54.03
54.04	03440	MAMMOGRAPHY	0.000000		54.04
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
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
66.01	06601	REHAB OUTPATIENT	0.000000		66.01
66.02	06602	REHAB MED SURGICAL	0.000000		66.02
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
70.01	07001	NEUROLOG	0.000000		70.01
70.02	07002	SLEEP LAB	0.000000		70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	DAY REHAB	0.000000		90.01
90.02	09002	IMAGING CENTERS	0.000000		90.02
90.03	09003	COUMADIN CLINIC	0.000000		90.03
90.04	09004	WOUND CLINIC	0.000000		90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part I Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	5,892,402	0	5,892,402	67,001	87.94	30.00
31.00	INTENSIVE CARE UNIT	1,222,262		1,222,262	9,702	125.98	31.00
40.00	SUBPROVIDER - IPF	538,698	0	538,698	5,466	98.55	40.00
41.00	SUBPROVIDER - IRF	2,062,073	0	2,062,073	21,457	96.10	41.00
43.00	NURSERY	158,273		158,273	5,405	29.28	43.00
200.00	Total (Lines 30-199)	9,873,708		9,873,708	109,031		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	32,713	2,876,781				
31.00	INTENSIVE CARE UNIT	4,235	533,525				
40.00	SUBPROVIDER - IPF	3,912	385,528				
41.00	SUBPROVIDER - IRF	14,848	1,426,893				
43.00	NURSERY	0	0				
200.00	Total (Lines 30-199)	55,708	5,222,727				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	2,173,922	164,641,864	0.013204	36,264,584	478,838	50.00	
50.01	05001 GAMMA KNIFE	163,353	13,850,223	0.011794	0	0	50.01	
50.02	03330 ENDOSCOPY	327,710	65,183,616	0.005027	5,896,303	29,641	50.02	
51.00	05100 RECOVERY ROOM	251,188	24,868,858	0.010101	5,264,028	53,172	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	668,701	11,648,235	0.057408	9,146	525	52.00	
53.00	05300 ANESTHESIOLOGY	588,423	36,881,553	0.015954	7,857,716	125,362	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	572,608	43,068,072	0.013295	8,607,068	114,431	54.00	
54.01	03630 ULTRA SOUND	249,342	29,899,117	0.008339	4,892,643	40,800	54.01	
54.02	05401 PET SCAN	47,577	12,129,647	0.003922	55,692	218	54.02	
54.03	03480 ONCOLOGY	604,571	50,726,763	0.011918	884,835	10,545	54.03	
54.04	03440 MAMMOGRAPHY	211,218	15,708,073	0.013446	32,913	443	54.04	
56.00	05600 RADIOISOTOPE	192,140	23,135,902	0.008305	4,259,204	35,373	56.00	
57.00	05700 CT SCAN	313,069	102,944,176	0.003041	18,356,328	55,822	57.00	
58.00	05800 MRI	249,610	41,154,752	0.006065	6,146,724	37,280	58.00	
59.00	05900 CARDIAC CATHETERIZATION	861,496	120,911,467	0.007125	29,439,307	209,755	59.00	
60.00	06000 LABORATORY	1,106,962	255,377,655	0.004335	48,388,065	209,762	60.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	81,799	9,541,032	0.008573	3,143,841	26,952	63.00	
64.00	06400 INTRAVENOUS THERAPY	63,702	3,147,972	0.020236	1,414,151	28,617	64.00	
65.00	06500 RESPIRATORY THERAPY	177,308	54,087,221	0.003278	33,705,248	110,486	65.00	
66.00	06600 PHYSICAL THERAPY	310,573	35,568,658	0.008732	1,809	16	66.00	
66.01	06601 REHAB OUTPATIENT	257,879	14,388,779	0.017922	0	0	66.01	
66.02	06602 REHAB MED SURGICAL	86,609	18,657,098	0.004642	10,172,240	47,220	66.02	
69.00	06900 ELECTROCARDIOLOGY	150,512	48,812,394	0.003083	13,395,545	41,298	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	92,166	3,999,698	0.023043	475,653	10,960	70.00	
70.01	07001 NEUROMEG	0	0	0.000000	0	0	70.01	
70.02	07002 SLEEP LAB	202,184	11,062,671	0.018276	5,595	102	70.02	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	950,138	138,636,056	0.006853	27,307,869	187,141	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	858,982	52,990,067	0.016210	18,322,739	297,012	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	854,117	180,659,396	0.004728	50,666,846	239,553	73.00	
74.00	07400 RENAL DIALYSIS	40,845	6,647,336	0.006145	3,451,835	21,212	74.00	
76.97	07697 CARDIAC REHABILITATION	138,386	2,085,856	0.066345	124,542	8,263	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	359,615	11,905,629	0.030205	349,698	10,563	90.00	
90.01	09001 DAY REHAB	89,959	8,369,203	0.010749	0	0	90.01	
90.02	09002 IMAGING CENTERS	100,810	17,420,374	0.005787	99,849	578	90.02	
90.03	09003 COUMADIN CLINIC	23,112	1,411,853	0.016370	2,508	41	90.03	
90.04	09004 WOUND CLINIC	219,919	18,828,436	0.011680	66,815	780	90.04	
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	417,457	53,128,071	0.007858	186,514	1,466	90.05	
91.00	09100 EMERGENCY	697,557	127,252,071	0.005482	19,740,822	108,219	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	256,800	7,414,179	0.034636	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00	
200.00	Total (Lines 50-199)	15,012,319	1,838,144,023		358,988,675	2,542,446	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/30/2017 11:23 am	
Title XVIII			Hospital		PPS			
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	452,343	0	0	452,343	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,486	0	0	68,486	31.00
40.00	04000	SUBPROVIDER - IPF	0	38,584	0	0	38,584	40.00
41.00	04100	SUBPROVIDER - IRF	0	151,464	0	0	151,464	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	710,877	0	0	710,877	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,001	6.75	32,713	220,813		30.00
31.00	03100	INTENSIVE CARE UNIT	9,702	7.06	4,235	29,899		31.00
40.00	04000	SUBPROVIDER - IPF	5,466	7.06	3,912	27,619		40.00
41.00	04100	SUBPROVIDER - IRF	21,457	7.06	14,848	104,827		41.00
43.00	04300	NURSERY	5,405	0.00	0	0		43.00
200.00		Total (lines 30-199)	109,031		55,708	383,158		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0258

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		Title XVIII				Hospital	PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001	GAMMA KNIFE	0	0	0	0	0	50.01
50.02	03330	ENDOSCOPY	0	0	0	0	0	50.02
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
54.02	05401	PET SCAN	0	0	0	0	0	54.02
54.03	03480	ONCOLOGY	0	0	0	0	0	54.03
54.04	03440	MAMMOGRAPHY	0	0	0	0	0	54.04
56.00	05600	RADIO SOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
66.01	06601	REHAB OUTPATIENT	0	0	0	0	0	66.01
66.02	06602	REHAB MED SURGICAL	0	0	0	0	0	66.02
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	NEUROLOG	0	0	0	0	0	70.01
70.02	07002	SLEEP LAB	0	0	0	0	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	DAY REHAB	0	0	0	0	0	90.01
90.02	09002	IMAGING CENTERS	0	0	0	0	0	90.02
90.03	09003	COUMADIN CLINIC	0	0	0	0	0	90.03
90.04	09004	WOUND CLINIC	0	0	0	0	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	19,715	0	19,715	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	19,715	0	19,715	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	164,641,864	0.000000	0.000000	36,264,584	50.00
50.01	05001	GAMMA KNIFE	0	13,850,223	0.000000	0.000000	0	50.01
50.02	03330	ENDOSCOPY	0	65,183,616	0.000000	0.000000	5,896,303	50.02
51.00	05100	RECOVERY ROOM	0	24,868,858	0.000000	0.000000	5,264,028	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,648,235	0.000000	0.000000	9,146	52.00
53.00	05300	ANESTHESIOLOGY	0	36,881,553	0.000000	0.000000	7,857,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,068,072	0.000000	0.000000	8,607,068	54.00
54.01	03630	ULTRA SOUND	0	29,899,117	0.000000	0.000000	4,892,643	54.01
54.02	05401	PET SCAN	0	12,129,647	0.000000	0.000000	55,692	54.02
54.03	03480	ONCOLOGY	0	50,726,763	0.000000	0.000000	884,835	54.03
54.04	03440	MAMMOGRAPHY	0	15,708,073	0.000000	0.000000	32,913	54.04
56.00	05600	RADIOISOTOPE	0	23,135,902	0.000000	0.000000	4,259,204	56.00
57.00	05700	CT SCAN	0	102,944,176	0.000000	0.000000	18,356,328	57.00
58.00	05800	MRI	0	41,154,752	0.000000	0.000000	6,146,724	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	120,911,467	0.000000	0.000000	29,439,307	59.00
60.00	06000	LABORATORY	0	255,377,655	0.000000	0.000000	48,388,065	60.00
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0	9,541,032	0.000000	0.000000	3,143,841	63.00
64.00	06400	INTRAVENOUS THERAPY	0	3,147,972	0.000000	0.000000	1,414,151	64.00
65.00	06500	RESPIRATORY THERAPY	0	54,087,221	0.000000	0.000000	33,705,248	65.00
66.00	06600	PHYSICAL THERAPY	0	35,568,658	0.000000	0.000000	1,809	66.00
66.01	06601	REHAB OUTPATIENT	0	14,388,779	0.000000	0.000000	0	66.01
66.02	06602	REHAB MED SURGICAL	0	18,657,098	0.000000	0.000000	10,172,240	66.02
69.00	06900	ELECTROCARDIOLOGY	0	48,812,394	0.000000	0.000000	13,395,545	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,999,698	0.000000	0.000000	475,653	70.00
70.01	07001	NEUROMEG	0	0	0.000000	0.000000	0	70.01
70.02	07002	SLEEP LAB	0	11,062,671	0.000000	0.000000	5,595	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	138,636,056	0.000000	0.000000	27,307,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	52,990,067	0.000000	0.000000	18,322,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	180,659,396	0.000000	0.000000	50,666,846	73.00
74.00	07400	RENAL DIALYSIS	0	6,647,336	0.000000	0.000000	3,451,835	74.00
76.97	07697	CARDIAC REHABILITATION	0	2,085,856	0.000000	0.000000	124,542	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	11,905,629	0.000000	0.000000	349,698	90.00
90.01	09001	DAY REHAB	0	8,369,203	0.000000	0.000000	0	90.01
90.02	09002	IMAGING CENTERS	0	17,420,374	0.000000	0.000000	99,849	90.02
90.03	09003	COUMADIN CLINIC	0	1,411,853	0.000000	0.000000	2,508	90.03
90.04	09004	WOUND CLINIC	0	18,828,436	0.000000	0.000000	66,815	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	53,128,071	0.000000	0.000000	186,514	90.05
91.00	09100	EMERGENCY	0	127,252,071	0.000000	0.000000	19,740,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	19,715	7,414,179	0.002659	0.002659	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (Lines 50-199)	19,715	1,838,144,023			358,988,675	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 11:23 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	13,782,112	0		50.00
50.01	05001 GAMMA KNIFE	0	4,775,202	0		50.01
50.02	03330 ENDOSCOPY	0	17,348,722	0		50.02
51.00	05100 RECOVERY ROOM	0	2,384,745	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	3,210,950	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,282,218	0		54.00
54.01	03630 ULTRASOUND	0	4,540,538	0		54.01
54.02	05401 PET SCAN	0	6,481,234	0		54.02
54.03	03480 ONCOLOGY	0	23,251,708	0		54.03
54.04	03440 MAMMOGRAPHY	0	1,241,164	0		54.04
56.00	05600 RADIOISOTOPE	0	6,411,631	0		56.00
57.00	05700 CT SCAN	0	20,142,117	0		57.00
58.00	05800 MRI	0	8,547,054	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	33,244,043	0		59.00
60.00	06000 LABORATORY	0	14,725,405	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	643,213	0		63.00
64.00	06400 INTRAVENOUS THERAPY	0	100,932	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	1,214,312	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
66.01	06601 REHAB OUTPATIENT	0	100,325	0		66.01
66.02	06602 REHAB MED SURGICAL	0	79,063	0		66.02
69.00	06900 ELECTROCARDIOLOGY	0	8,655,963	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	832,044	0		70.00
70.01	07001 NEUROMEG	0	0	0		70.01
70.02	07002 SLEEP LAB	0	2,628,592	0		70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,013,200	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8,031,155	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	25,506,268	0		73.00
74.00	07400 RENAL DIALYSIS	0	229,435	0		74.00
76.97	07697 CARDIAC REHABILITATION	0	900,832	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	5,276,584	0		90.00
90.01	09001 DAY REHAB	0	49,420	0		90.01
90.02	09002 IMAGING CENTERS	0	5,205,772	0		90.02
90.03	09003 COUMADIN CLINIC	0	839,967	0		90.03
90.04	09004 WOUND CLINIC	0	9,428,412	0		90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	0	23,972,048	0		90.05
91.00	09100 EMERGENCY	0	17,275,602	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,671,999	4,446		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0		94.00
200.00	Total (Lines 50-199)	0	302,023,981	4,446		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 11:23 am			
		Title XVIII	Hospital	PPS			
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.137028	13,782,112	0	0	1,888,535	50.00
50.01	05001 GAMMA KNIFE	0.253982	4,775,202	0	0	1,212,815	50.01
50.02	03330 ENDOSCOPY	0.087046	17,348,722	0	0	1,510,137	50.02
51.00	05100 RECOVERY ROOM	0.134841	2,384,745	0	0	321,561	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.456311	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.039614	3,210,950	0	0	127,199	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.122164	7,282,218	0	0	889,625	54.00
54.01	03630 ULTRA SOUND	0.087615	4,540,538	0	0	397,819	54.01
54.02	05401 PET SCAN	0.037021	6,481,234	0	0	239,942	54.02
54.03	03480 ONCOLOGY	0.076900	23,251,708	0	0	1,788,056	54.03
54.04	03440 MAMMOGRAPHY	0.143769	1,241,164	0	0	178,441	54.04
56.00	05600 RADIOISOTOPE	0.062537	6,411,631	0	0	400,964	56.00
57.00	05700 CT SCAN	0.039179	20,142,117	0	0	789,148	57.00
58.00	05800 MRI	0.069613	8,547,054	0	0	594,986	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.110098	33,244,043	0	0	3,660,103	59.00
60.00	06000 LABORATORY	0.082964	14,725,405	3,483	0	1,221,679	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.335630	643,213	0	0	215,882	63.00
64.00	06400 INTRAVENOUS THERAPY	0.824733	100,932	0	0	83,242	64.00
65.00	06500 RESPIRATORY THERAPY	0.095755	1,214,312	0	0	116,276	65.00
66.00	06600 PHYSICAL THERAPY	0.057794	0	0	0	0	66.00
66.01	06601 REHAB OUTPATIENT	0.281957	100,325	0	0	28,287	66.01
66.02	06602 REHAB MED SURGICAL	0.188210	79,063	0	0	14,880	66.02
69.00	06900 ELECTROCARDIOLOGY	0.050510	8,655,963	0	0	437,213	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.133255	832,044	0	0	110,874	70.00
70.01	07001 NEUROLOG	0.000000	0	0	0	0	70.01
70.02	07002 SLEEP LAB	0.152267	2,628,592	0	0	400,248	70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.320879	22,013,200	780	0	7,063,574	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.718641	8,031,155	0	0	5,771,517	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213859	25,506,268	0	48,979	5,454,745	73.00
74.00	07400 RENAL DIALYSIS	0.126428	229,435	0	0	29,007	74.00
76.97	07697 CARDIAC REHABILITATION	0.541999	900,832	0	0	488,250	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.269023	5,276,584	0	0	1,419,522	90.00
90.01	09001 DAY REHAB	0.204125	49,420	0	0	10,088	90.01
90.02	09002 IMAGING CENTERS	0.119227	5,205,772	0	0	620,669	90.02
90.03	09003 COUMADIN CLINIC	0.270491	839,967	0	0	227,204	90.03
90.04	09004 WOUND CLINIC	0.101675	9,428,412	0	0	958,634	90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	0.075802	23,972,048	0	0	1,817,129	90.05
91.00	09100 EMERGENCY	0.102540	17,275,602	38,880	0	1,771,440	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.496664	1,671,999	0	0	830,422	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00	Subtotal (see instructions)		302,023,981	43,143	48,979	43,090,113	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		302,023,981	43,143	48,979	43,090,113	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII	Hospital	PPS	
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	05001	GAMMA KNIFE	0	0	50.01
50.02	03330	ENDOSCOPY	0	0	50.02
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	05401	PET SCAN	0	0	54.02
54.03	03480	ONCOLOGY	0	0	54.03
54.04	03440	MAMMOGRAPHY	0	0	54.04
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	289	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
66.01	06601	REHAB OUTPATIENT	0	0	66.01
66.02	06602	REHAB MED SURGICAL	0	0	66.02
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEUROMEG	0	0	70.01
70.02	07002	SLEEP LAB	0	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	250	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,475	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	DAY REHAB	0	0	90.01
90.02	09002	IMAGING CENTERS	0	0	90.02
90.03	09003	COUMADIN CLINIC	0	0	90.03
90.04	09004	WOUND CLINIC	0	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	0	90.05
91.00	09100	EMERGENCY	3,987	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
200.00		Subtotal (see instructions)	4,526	10,475	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,526	10,475	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0258 Component CCN: 14-S258		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part II Date/Time Prepared: 11/30/2017 11:23 am	
Title XVIII				Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,173,922	164,641,864	0.013204	0	50.00
50.01	05001	GAMMA KNIFE	163,353	13,850,223	0.011794	0	50.01
50.02	03330	ENDOSCOPY	327,710	65,183,616	0.005027	0	50.02
51.00	05100	RECOVERY ROOM	251,188	24,868,858	0.010101	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	668,701	11,648,235	0.057408	0	52.00
53.00	05300	ANESTHESIOLOGY	588,423	36,881,553	0.015954	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,608	43,068,072	0.013295	138,081	1,836
54.01	03630	ULTRA SOUND	249,342	29,899,117	0.008339	42,476	354
54.02	05401	PET SCAN	47,577	12,129,647	0.003922	0	0
54.03	03480	ONCOLOGY	604,571	50,726,763	0.011918	0	0
54.04	03440	MAMMOGRAPHY	211,218	15,708,073	0.013446	0	0
56.00	05600	RADIOLOGY-SOFT	192,140	23,135,902	0.008305	4,697	39
57.00	05700	CT SCAN	313,069	102,944,176	0.003041	293,318	892
58.00	05800	MRI	249,610	41,154,752	0.006065	22,737	138
59.00	05900	CARDIAC CATHETERIZATION	861,496	120,911,467	0.007125	0	0
60.00	06000	LABORATORY	1,106,962	255,377,655	0.004335	1,721,610	7,463
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	81,799	9,541,032	0.008573	770	7
64.00	06400	INTRAVENOUS THERAPY	63,702	3,147,972	0.020236	1,066	22
65.00	06500	RESPIRATORY THERAPY	177,308	54,087,221	0.003278	78,547	257
66.00	06600	PHYSICAL THERAPY	310,573	35,568,658	0.008732	0	0
66.01	06601	REHAB OUTPATIENT	257,879	14,388,779	0.017922	0	0
66.02	06602	REHAB MED SURGICAL	86,609	18,657,098	0.004642	227,033	1,054
69.00	06900	ELECTROCARDIOLOGY	150,512	48,812,394	0.003083	135,754	419
70.00	07000	ELECTROENCEPHALOGRAPHY	92,166	3,999,698	0.023043	1,486	34
70.01	07001	NEUROLOG	0	0	0.000000	0	0
70.02	07002	SLEEP LAB	202,184	11,062,671	0.018276	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	950,138	138,636,056	0.006853	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	858,982	52,990,067	0.016210	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	854,117	180,659,396	0.004728	1,068,976	5,054
74.00	07400	RENAL DIALYSIS	40,845	6,647,336	0.006145	0	0
76.97	07697	CARDIAC REHABILITATION	138,386	2,085,856	0.066345	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699	LITHOTRIpsy	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	359,615	11,905,629	0.030205	1,472	44
90.01	09001	DAY REHAB	89,959	8,369,203	0.010749	0	0
90.02	09002	IMAGING CENTERS	100,810	17,420,374	0.005787	0	0
90.03	09003	COUMADIN CLINIC	23,112	1,411,853	0.016370	0	0
90.04	09004	WOUND CLINIC	219,919	18,828,436	0.011680	0	0
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	417,457	53,128,071	0.007858	0	0
91.00	09100	EMERGENCY	697,557	127,252,071	0.005482	513,409	2,815
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,414,179	0.000000	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0
200.00		Total (Lines 50-199)	14,755,519	1,838,144,023		4,251,432	20,428

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0258
Component CCN: 14-S258

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01	05001 GAMMA KNIFE	0	0	0	0	0	50.01
50.02	03330 ENDOSCOPY	0	0	0	0	0	50.02
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630 ULTRASOUND	0	0	0	0	0	54.01
54.02	05401 PET SCAN	0	0	0	0	0	54.02
54.03	03480 ONCOLOGY	0	0	0	0	0	54.03
54.04	03440 MAMMOGRAPHY	0	0	0	0	0	54.04
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
66.01	06601 REHAB OUTPATIENT	0	0	0	0	0	66.01
66.02	06602 REHAB MED SURGICAL	0	0	0	0	0	66.02
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001 NEUROMEG	0	0	0	0	0	70.01
70.02	07002 SLEEP LAB	0	0	0	0	0	70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 DAY REHAB	0	0	0	0	0	90.01
90.02	09002 IMAGING CENTERS	0	0	0	0	0	90.02
90.03	09003 COUMADIN CLINIC	0	0	0	0	0	90.03
90.04	09004 WOUND CLINIC	0	0	0	0	0	90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	0	0	0	0	0	90.05
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
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 11:23 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	164,641,864	0.000000	0.000000	0	50.00
50.01 05001 GAMMA KNIFE	0	13,850,223	0.000000	0.000000	0	50.01
50.02 03330 ENDOSCOPY	0	65,183,616	0.000000	0.000000	0	50.02
51.00 05100 RECOVERY ROOM	0	24,868,858	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	11,648,235	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	36,881,553	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	43,068,072	0.000000	0.000000	138,081	54.00
54.01 03630 ULTRA SOUND	0	29,899,117	0.000000	0.000000	42,476	54.01
54.02 05401 PET SCAN	0	12,129,647	0.000000	0.000000	0	54.02
54.03 03480 ONCOLOGY	0	50,726,763	0.000000	0.000000	0	54.03
54.04 03440 MAMMOGRAPHY	0	15,708,073	0.000000	0.000000	0	54.04
56.00 05600 RADIOLOGY	0	23,135,902	0.000000	0.000000	4,697	56.00
57.00 05700 CT SCAN	0	102,944,176	0.000000	0.000000	293,318	57.00
58.00 05800 MRI	0	41,154,752	0.000000	0.000000	22,737	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	120,911,467	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	255,377,655	0.000000	0.000000	1,721,610	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	9,541,032	0.000000	0.000000	770	63.00
64.00 06400 INTRAVENOUS THERAPY	0	3,147,972	0.000000	0.000000	1,066	64.00
65.00 06500 RESPIRATORY THERAPY	0	54,087,221	0.000000	0.000000	78,547	65.00
66.00 06600 PHYSICAL THERAPY	0	35,568,658	0.000000	0.000000	0	66.00
66.01 06601 REHAB OUTPATIENT	0	14,388,779	0.000000	0.000000	0	66.01
66.02 06602 REHAB MED SURGICAL	0	18,657,098	0.000000	0.000000	227,033	66.02
69.00 06900 ELECTROCARDIOLOGY	0	48,812,394	0.000000	0.000000	135,754	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	3,999,698	0.000000	0.000000	1,486	70.00
70.01 07001 NEUROSEG	0	0	0.000000	0.000000	0	70.01
70.02 07002 SLEEP LAB	0	11,062,671	0.000000	0.000000	0	70.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	138,636,056	0.000000	0.000000	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	52,990,067	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	180,659,396	0.000000	0.000000	1,068,976	73.00
74.00 07400 RENAL DIALYSIS	0	6,647,336	0.000000	0.000000	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	2,085,856	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	11,905,629	0.000000	0.000000	1,472	90.00
90.01 09001 DAY REHAB	0	8,369,203	0.000000	0.000000	0	90.01
90.02 09002 IMAGING CENTERS	0	17,420,374	0.000000	0.000000	0	90.02
90.03 09003 COUMADIN CLINIC	0	1,411,853	0.000000	0.000000	0	90.03
90.04 09004 WOUND CLINIC	0	18,828,436	0.000000	0.000000	0	90.04
90.05 09005 CARDIOVASCULAR IMAGING CENTERS	0	53,128,071	0.000000	0.000000	0	90.05
91.00 09100 EMERGENCY	0	127,252,071	0.000000	0.000000	513,409	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7,414,179	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00	Total (Lines 50-199)	1,838,144,023			4,251,432	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 11:23 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
50.01 05001 GAMMA KNIFE	0	0	0	50.01
50.02 03330 ENDOSCOPY	0	0	0	50.02
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	1,515	0	54.00
54.01 03630 ULTRA SOUND	0	0	0	54.01
54.02 05401 PET SCAN	0	0	0	54.02
54.03 03480 ONCOLOGY	0	0	0	54.03
54.04 03440 MAMMOGRAPHY	0	0	0	54.04
56.00 05600 RADIOISOTOPE	0	0	0	56.00
57.00 05700 CT SCAN	0	6,120	0	57.00
58.00 05800 MRI	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	1,678	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
66.01 06601 REHAB OUTPATIENT	0	0	0	66.01
66.02 06602 REHAB MED SURGICAL	0	0	0	66.02
69.00 06900 ELECTROCARDIOLOGY	0	2,717	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01 07001 NEUROMEG	0	0	0	70.01
70.02 07002 SLEEP LAB	0	0	0	70.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1,776	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 DAY REHAB	0	0	0	90.01
90.02 09002 IMAGING CENTERS	0	0	0	90.02
90.03 09003 COUMADIN CLINIC	0	0	0	90.03
90.04 09004 WOUND CLINIC	0	0	0	90.04
90.05 09005 CARDIOVASCULAR IMAGING CENTERS	0	0	0	90.05
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00 Total (Lines 50-199)	0	13,806	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 11:23 am			
		Title XVIII	Subprovider - IPF	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	0.137028	0	0	0	0	50.00
50.01	05001 GAMMA KNIFE	0.253982	0	0	0	0	50.01
50.02	03330 ENDOSCOPY	0.087046	0	0	0	0	50.02
51.00	05100 RECOVERY ROOM	0.134841	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.456311	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.039614	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.122164	1,515	0	0	185	54.00
54.01	03630 ULTRASOUND	0.087615	0	0	0	0	54.01
54.02	05401 PET SCAN	0.037021	0	0	0	0	54.02
54.03	03480 ONCOLOGY	0.076900	0	0	0	0	54.03
54.04	03440 MAMMOGRAPHY	0.143769	0	0	0	0	54.04
56.00	05600 RADIOISOTOPE	0.062537	0	0	0	0	56.00
57.00	05700 CT SCAN	0.039179	6,120	0	0	240	57.00
58.00	05800 MRI	0.069613	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.110098	0	0	0	0	59.00
60.00	06000 LABORATORY	0.082964	1,678	0	0	139	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.335630	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.824733	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.095755	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.057794	0	0	0	0	66.00
66.01	06601 REHAB OUTPATIENT	0.281957	0	0	0	0	66.01
66.02	06602 REHAB MED SURGICAL	0.188210	0	0	0	0	66.02
69.00	06900 ELECTROCARDIOLOGY	0.050510	2,717	0	0	137	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.133255	0	0	0	0	70.00
70.01	07001 NEUROMEG	0.000000	0	0	0	0	70.01
70.02	07002 SLEEP LAB	0.152267	0	0	0	0	70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.320879	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.718641	0	0	1,864	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213859	1,776	0	0	380	73.00
74.00	07400 RENAL DIALYSIS	0.126428	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.541999	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.269023	0	0	0	0	90.00
90.01	09001 DAY REHAB	0.204125	0	0	0	0	90.01
90.02	09002 IMAGING CENTERS	0.119227	0	0	0	0	90.02
90.03	09003 COUMADIN CLINIC	0.270491	0	0	0	0	90.03
90.04	09004 WOUND CLINIC	0.101675	0	0	0	0	90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	0.075802	0	0	0	0	90.05
91.00	09100 EMERGENCY	0.102540	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.496664	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00	Subtotal (see instructions)		13,806	0	0	1,081	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		13,806	0	0	1,081	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
50.01	05001	GAMMA KNIFE	0	0	50.01
50.02	03330	ENDOSCOPY	0	0	50.02
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	54.01
54.02	05401	PET SCAN	0	0	54.02
54.03	03480	ONCOLOGY	0	0	54.03
54.04	03440	MAMMOGRAPHY	0	0	54.04
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
66.01	06601	REHAB OUTPATIENT	0	0	66.01
66.02	06602	REHAB MED SURGICAL	0	0	66.02
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	NEUROLOG	0	0	70.01
70.02	07002	SLEEP LAB	0	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	DAY REHAB	0	0	90.01
90.02	09002	IMAGING CENTERS	0	0	90.02
90.03	09003	COUMADIN CLINIC	0	0	90.03
90.04	09004	WOUND CLINIC	0	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	0	90.05
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
200.00		Subtotal (see instructions)	0	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	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0258 Component CCN: 14-T258		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part II Date/Time Prepared: 11/30/2017 11:23 am		
Title XVIII				Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,173,922	164,641,864	0.013204	19,868	262	50.00
50.01	05001	GAMMA KNIFE	163,353	13,850,223	0.011794	0	0	50.01
50.02	03330	ENDOSCOPY	327,710	65,183,616	0.005027	119,255	599	50.02
51.00	05100	RECOVERY ROOM	251,188	24,868,858	0.010101	4,917	50	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	668,701	11,648,235	0.057408	0	0	52.00
53.00	05300	ANESTHESIOLOGY	588,423	36,881,553	0.015954	3,775	60	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	572,608	43,068,072	0.013295	402,378	5,350	54.00
54.01	03630	ULTRA SOUND	249,342	29,899,117	0.008339	386,289	3,221	54.01
54.02	05401	PET SCAN	47,577	12,129,647	0.003922	0	0	54.02
54.03	03480	ONCOLOGY	604,571	50,726,763	0.011918	264,994	3,158	54.03
54.04	03440	MAMMOGRAPHY	211,218	15,708,073	0.013446	0	0	54.04
56.00	05600	RADIOISOTOPE	192,140	23,135,902	0.008305	72,909	606	56.00
57.00	05700	CT SCAN	313,069	102,944,176	0.003041	512,165	1,557	57.00
58.00	05800	MRI	249,610	41,154,752	0.006065	161,937	982	58.00
59.00	05900	CARDIAC CATHETERIZATION	861,496	120,911,467	0.007125	169,808	1,210	59.00
60.00	06000	LABORATORY	1,106,962	255,377,655	0.004335	5,721,421	24,802	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	81,799	9,541,032	0.008573	71,639	614	63.00
64.00	06400	INTRAVENOUS THERAPY	63,702	3,147,972	0.020236	42,542	861	64.00
65.00	06500	RESPIRATORY THERAPY	177,308	54,087,221	0.003278	1,604,296	5,259	65.00
66.00	06600	PHYSICAL THERAPY	310,573	35,568,658	0.008732	22,514,689	196,598	66.00
66.01	06601	REHAB OUTPATIENT	257,879	14,388,779	0.017922	0	0	66.01
66.02	06602	REHAB MED SURGICAL	86,609	18,657,098	0.004642	7,437	35	66.02
69.00	06900	ELECTROCARDIOLOGY	150,512	48,812,394	0.003083	121,211	374	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,166	3,999,698	0.023043	11,552	266	70.00
70.01	07001	NEUROLOG	0	0	0.000000	0	0	70.01
70.02	07002	SLEEP LAB	202,184	11,062,671	0.018276	0	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	950,138	138,636,056	0.006853	141,923	973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	858,982	52,990,067	0.016210	11,840	192	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	854,117	180,659,396	0.004728	5,962,575	28,191	73.00
74.00	07400	RENAL DIALYSIS	40,845	6,647,336	0.006145	795,983	4,891	74.00
76.97	07697	CARDIAC REHABILITATION	138,386	2,085,856	0.066345	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	359,615	11,905,629	0.030205	18,408	556	90.00
90.01	09001	DAY REHAB	89,959	8,369,203	0.010749	0	0	90.01
90.02	09002	IMAGING CENTERS	100,810	17,420,374	0.005787	0	0	90.02
90.03	09003	COUMADIN CLINIC	23,112	1,411,853	0.016370	0	0	90.03
90.04	09004	WOUND CLINIC	219,919	18,828,436	0.011680	0	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	417,457	53,128,071	0.007858	4,587	36	90.05
91.00	09100	EMERGENCY	697,557	127,252,071	0.005482	43,761	240	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	7,414,179	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (Lines 50-199)	14,755,519	1,838,144,023		39,192,159	280,943	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 11:23 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
50.01 05001 GAMMA KNIFE	0	0	0	0	0	50.01
50.02 03330 ENDOSCOPY	0	0	0	0	0	50.02
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03630 ULTRASOUND	0	0	0	0	0	54.01
54.02 05401 PET SCAN	0	0	0	0	0	54.02
54.03 03480 ONCOLOGY	0	0	0	0	0	54.03
54.04 03440 MAMMOGRAPHY	0	0	0	0	0	54.04
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
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
66.01 06601 REHAB OUTPATIENT	0	0	0	0	0	66.01
66.02 06602 REHAB MED SURGICAL	0	0	0	0	0	66.02
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01 07001 NEUROMEG	0	0	0	0	0	70.01
70.02 07002 SLEEP LAB	0	0	0	0	0	70.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 DAY REHAB	0	0	0	0	0	90.01
90.02 09002 IMAGING CENTERS	0	0	0	0	0	90.02
90.03 09003 COUMADIN CLINIC	0	0	0	0	0	90.03
90.04 09004 WOUND CLINIC	0	0	0	0	0	90.04
90.05 09005 CARDIOVASCULAR IMAGING CENTERS	0	0	0	0	0	90.05
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
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00 Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 11:23 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	164,641,864	0.000000	0.000000	19,868	50.00
50.01 05001 GAMMA KNIFE	0	13,850,223	0.000000	0.000000	0	50.01
50.02 03330 ENDOSCOPY	0	65,183,616	0.000000	0.000000	119,255	50.02
51.00 05100 RECOVERY ROOM	0	24,868,858	0.000000	0.000000	4,917	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	11,648,235	0.000000	0.000000	0	52.00
53.00 05300 ANESTHESIOLOGY	0	36,881,553	0.000000	0.000000	3,775	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	43,068,072	0.000000	0.000000	402,378	54.00
54.01 03630 ULTRA SOUND	0	29,899,117	0.000000	0.000000	386,289	54.01
54.02 05401 PET SCAN	0	12,129,647	0.000000	0.000000	0	54.02
54.03 03480 ONCOLOGY	0	50,726,763	0.000000	0.000000	264,994	54.03
54.04 03440 MAMMOGRAPHY	0	15,708,073	0.000000	0.000000	0	54.04
56.00 05600 RADIOISOTOPE	0	23,135,902	0.000000	0.000000	72,909	56.00
57.00 05700 CT SCAN	0	102,944,176	0.000000	0.000000	512,165	57.00
58.00 05800 MRI	0	41,154,752	0.000000	0.000000	161,937	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	120,911,467	0.000000	0.000000	169,808	59.00
60.00 06000 LABORATORY	0	255,377,655	0.000000	0.000000	5,721,421	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	9,541,032	0.000000	0.000000	71,639	63.00
64.00 06400 INTRAVENOUS THERAPY	0	3,147,972	0.000000	0.000000	42,542	64.00
65.00 06500 RESPIRATORY THERAPY	0	54,087,221	0.000000	0.000000	1,604,296	65.00
66.00 06600 PHYSICAL THERAPY	0	35,568,658	0.000000	0.000000	22,514,689	66.00
66.01 06601 REHAB OUTPATIENT	0	14,388,779	0.000000	0.000000	0	66.01
66.02 06602 REHAB MED SURGICAL	0	18,657,098	0.000000	0.000000	7,437	66.02
69.00 06900 ELECTROCARDIOLOGY	0	48,812,394	0.000000	0.000000	121,211	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	3,999,698	0.000000	0.000000	11,552	70.00
70.01 07001 NEUROLOG	0	0	0.000000	0.000000	0	70.01
70.02 07002 SLEEP LAB	0	11,062,671	0.000000	0.000000	0	70.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	138,636,056	0.000000	0.000000	141,923	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	52,990,067	0.000000	0.000000	11,840	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	180,659,396	0.000000	0.000000	5,962,575	73.00
74.00 07400 RENAL DIALYSIS	0	6,647,336	0.000000	0.000000	795,983	74.00
76.97 07697 CARDIAC REHABILITATION	0	2,085,856	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	11,905,629	0.000000	0.000000	18,408	90.00
90.01 09001 DAY REHAB	0	8,369,203	0.000000	0.000000	0	90.01
90.02 09002 IMAGING CENTERS	0	17,420,374	0.000000	0.000000	0	90.02
90.03 09003 COUMADIN CLINIC	0	1,411,853	0.000000	0.000000	0	90.03
90.04 09004 WOUND CLINIC	0	18,828,436	0.000000	0.000000	0	90.04
90.05 09005 CARDIOVASCULAR IMAGING CENTERS	0	53,128,071	0.000000	0.000000	4,587	90.05
91.00 09100 EMERGENCY	0	127,252,071	0.000000	0.000000	43,761	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,414,179	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (Lines 50-199)			39,192,159	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 11:23 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
50.01	05001 GAMMA KNIFE	0	0	0	50.01
50.02	03330 ENDOSCOPY	0	0	0	50.02
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	3,635	0	54.00
54.01	03630 ULTRA SOUND	0	0	0	54.01
54.02	05401 PET SCAN	0	0	0	54.02
54.03	03480 ONCOLOGY	0	0	0	54.03
54.04	03440 MAMMOGRAPHY	0	0	0	54.04
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	10,102	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	5,552	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
66.01	06601 REHAB OUTPATIENT	0	0	0	66.01
66.02	06602 REHAB MED SURGICAL	0	0	0	66.02
69.00	06900 ELECTROCARDIOLOGY	0	4,330	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001 NEUROMEG	0	0	0	70.01
70.02	07002 SLEEP LAB	0	0	0	70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	28	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 DAY REHAB	0	0	0	90.01
90.02	09002 IMAGING CENTERS	0	0	0	90.02
90.03	09003 COUMADIN CLINIC	0	0	0	90.03
90.04	09004 WOUND CLINIC	0	0	0	90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	0	0	0	90.05
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (Lines 50-199)	0	23,647	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 11:23 am		
		Component CCN: 14-T258		PPS		
		Title XVIII	Subprovider - IRF			
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	0	0	50.00
50.01	05001	GAMMA KNIFE	0	0	0	50.01
50.02	03330	ENDOSCOPY	0	0	0	50.02
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,635	0	0	444 54.00
54.01	03630	ULTRA SOUND	0	0	0	54.01
54.02	05401	PET SCAN	0	0	0	54.02
54.03	03480	ONCOLOGY	0	0	0	54.03
54.04	03440	MAMMOGRAPHY	0	0	0	54.04
56.00	05600	RADIO SOTOP	0	0	0	56.00
57.00	05700	CT SCAN	10,102	0	0	396 57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	5,552	0	0	461 60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
66.01	06601	REHAB OUTPATIENT	0	0	0	66.01
66.02	06602	REHAB MED SURGICAL	0	0	0	66.02
69.00	06900	ELECTROCARDIOLOGY	4,330	0	0	219 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01	07001	NEUROMEG	0	0	0	70.01
70.02	07002	SLEEP LAB	0	0	0	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28	0	0	6 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	DAY REHAB	0	0	0	90.01
90.02	09002	IMAGING CENTERS	0	0	0	90.02
90.03	09003	COUMADIN CLINIC	0	0	0	90.03
90.04	09004	WOUND CLINIC	0	0	0	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00		Subtotal (see instructions)	23,647	0	0	1,526 200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	201.00
202.00		Net Charges (line 200 +/- line 201)	23,647	0	0	1,526 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 11:23 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
50.01 05001 GAMMA KNIFE	0	0	50.01
50.02 03330 ENDOSCOPY	0	0	50.02
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03630 ULTRA SOUND	0	0	54.01
54.02 05401 PET SCAN	0	0	54.02
54.03 03480 ONCOLOGY	0	0	54.03
54.04 03440 MAMMOGRAPHY	0	0	54.04
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
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
66.01 06601 REHAB OUTPATIENT	0	0	66.01
66.02 06602 REHAB MED SURGICAL	0	0	66.02
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01 07001 NEUROLOG	0	0	70.01
70.02 07002 SLEEP LAB	0	0	70.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 DAY REHAB	0	0	90.01
90.02 09002 IMAGING CENTERS	0	0	90.02
90.03 09003 COUMADIN CLINIC	0	0	90.03
90.04 09004 WOUND CLINIC	0	0	90.04
90.05 09005 CARDIOVASCULAR IMAGING CENTERS	0	0	90.05
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	452,343	0	0	452,343	30.00
31.00	03100	INTENSIVE CARE UNIT	0	68,486	0	0	68,486	31.00
40.00	04000	SUBPROVIDER - IPF	0	38,584	0	0	38,584	40.00
41.00	04100	SUBPROVIDER - IRF	0	151,464	0	0	151,464	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	710,877	0	0	710,877	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	67,001	6.75	3,752	25,326		30.00
31.00	03100	INTENSIVE CARE UNIT	9,702	7.06	226	1,596		31.00
40.00	04000	SUBPROVIDER - IPF	5,466	7.06	37	261		40.00
41.00	04100	SUBPROVIDER - IRF	21,457	7.06	207	1,461		41.00
43.00	04300	NURSERY	5,405	0.00	801	0		43.00
200.00		Total (lines 30-199)	109,031		5,023	28,644		200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		67,001	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		67,001	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)		64,081	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)		32,713	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)		84,493,420	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)		84,493,420	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)		84,493,420	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)		1,261.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		41,253,710	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)		41,253,710	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
Title XVIII			Hospital	PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	20,253,060	9,702	2,087.51	4,235	8,840,605	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)					60,268,846	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					110,363,161	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)					3,661,018	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,542,446	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					6,203,464	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					104,159,697	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,920	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,261.08	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,682,354	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	5,892,402	84,493,420	0.069738	3,682,354	256,800	90.00
91.00	Nursing School cost	0	84,493,420	0.000000	3,682,354	0	91.00
92.00	Allied health cost	452,343	84,493,420	0.005354	3,682,354	19,715	92.00
93.00	All other Medical Education	0	84,493,420	0.000000	3,682,354	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,466	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,466	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)		5,466	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)		3,912	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)		5,890,883	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)		5,890,883	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)		5,890,883	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)		1,077.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,216,080	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)		4,216,080	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1	
				Component CCN: 14-S258		Date/Time Prepared: 11/30/2017 11:23 am	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00	
44.00 CORONARY CARE UNIT						44.00	
45.00 BURN INTENSIVE CARE UNIT						45.00	
46.00 SURGICAL INTENSIVE CARE UNIT						46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					517,181	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,733,261	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)					413,147	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					20,428	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					433,575	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					4,299,686	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258 Component CCN: 14-S258		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	538,698	5,890,883	0.091446	0	0	90.00
91.00	Nursing School cost	0	5,890,883	0.000000	0	0	91.00
92.00	Allied health cost	38,584	5,890,883	0.006550	0	0	92.00
93.00	All other Medical Education	0	5,890,883	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		21,457	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		21,457	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)		21,457	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)		14,848	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)		36,196,826	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)		36,196,826	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)		36,196,826	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)		1,686.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		25,047,834	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)		25,047,834	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1
				Component CCN: 14-T258		Date/Time Prepared: 11/30/2017 11:23 am
				Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,609,232	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					28,657,066	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)					1,531,720	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					280,943	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,812,663	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					26,844,403	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258 Component CCN: 14-T258		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,062,073	36,196,826	0.056968	0	0	90.00
91.00	Nursing School cost	0	36,196,826	0.000000	0	0	91.00
92.00	Allied health cost	151,464	36,196,826	0.004184	0	0	92.00
93.00	All other Medical Education	0	36,196,826	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		67,001	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		67,001	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)		64,081	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)		3,752	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		5,405	15.00
16.00	Nursery days (title V or XIX only)		801	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)		84,493,420	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)		84,493,420	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)		84,493,420	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)		1,261.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,731,572	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)		4,731,572	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
Title XIX			Hospital		Cost	
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)	2,698,279	5,405	499.22	801	399,875	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	20,253,060	9,702	2,087.51	226	471,777	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,603,224	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,920	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,261.08	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,682,354	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	5,892,402	84,493,420	0.069738	3,682,354	256,800	90.00
91.00	Nursing School cost	0	84,493,420	0.000000	3,682,354	0	91.00
92.00	Allied health cost	452,343	84,493,420	0.005354	3,682,354	19,715	92.00
93.00	All other Medical Education	0	84,493,420	0.000000	3,682,354	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am
		Title XIX	Subprovider - IRF	Cost
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)			21,457 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			21,457 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)			21,457 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)			207 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			5,405 15.00
16.00	Nursery days (title V or XIX only)			801 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)			36,196,826 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)			36,196,826 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)			36,196,826 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)			1,686.95 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			349,199 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)			349,199 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258 Component CCN: 14-T258		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	INTENSIVE CARE Type Inpatient Hospital Units	0	0	0.00	0	0	
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44.00	CORONARY CARE UNIT						
45.00	BURN INTENSIVE CARE UNIT						
46.00	SURGICAL INTENSIVE CARE UNIT						
47.00	OTHER SPECIAL CARE (SPECIFY)						
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					349,199	
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	
55.00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	
58.00	Bonus payment (see instructions)					0	
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	
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	
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	
62.00	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	
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	
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	
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	
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	
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00	
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00	
72.00	Program routine service cost (line 9 x line 71)					72.00	
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00	
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00	
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00	
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00	
77.00	Program capital-related costs (line 9 x line 76)					77.00	
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00	
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00	
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00	
81.00	Inpatient routine service cost per diem limitation					81.00	
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00	
83.00	Reasonable inpatient routine service costs (see instructions)					83.00	
84.00	Program inpatient ancillary services (see instructions)					84.00	
85.00	Utilization review - physician compensation (see instructions)					85.00	
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0258 Component CCN: 14-T258		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 11:23 am	
		Title XIX		Subprovider - IRF		Cost	
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	2,062,073	36,196,826	0.056968	0	0	90.00
91.00	Nursing School cost	0	36,196,826	0.000000	0	0	91.00
92.00	Allied health cost	151,464	36,196,826	0.004184	0	0	92.00
93.00	All other Medical Education	0	36,196,826	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/30/2017 11:23 am	
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		89,201,695	30.00
31.00	03100	INTENSIVE CARE UNIT		22,375,007	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.137028	36,264,584	50.00
50.01	05001	GAMMA KNIFE	0.253982	0	50.01
50.02	03330	ENDOSCOPY	0.087046	5,896,303	50.02
51.00	05100	RECOVERY ROOM	0.134841	5,264,028	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.456311	9,146	52.00
53.00	05300	ANESTHESIOLOGY	0.039614	7,857,716	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.122164	8,607,068	54.00
54.01	03630	ULTRA SOUND	0.087615	4,892,643	54.01
54.02	05401	PET SCAN	0.037021	55,692	54.02
54.03	03480	ONCOLOGY	0.076900	884,835	54.03
54.04	03440	MAMMOGRAPHY	0.143769	32,913	54.04
56.00	05600	RADIOISOTOPE	0.062537	4,259,204	56.00
57.00	05700	CT SCAN	0.039179	18,356,328	57.00
58.00	05800	MRI	0.069613	6,146,724	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.110098	29,439,307	59.00
60.00	06000	LABORATORY	0.082964	48,388,065	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.335630	3,143,841	63.00
64.00	06400	INTRAVENOUS THERAPY	0.824733	1,414,151	64.00
65.00	06500	RESPIRATORY THERAPY	0.095755	33,705,248	65.00
66.00	06600	PHYSICAL THERAPY	0.057794	1,809	66.00
66.01	06601	REHAB OUTPATIENT	0.281957	0	66.01
66.02	06602	REHAB MED SURGICAL	0.188210	10,172,240	66.02
69.00	06900	ELECTROCARDIOLOGY	0.050510	13,395,545	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.133255	475,653	70.00
70.01	07001	NEUROMEG	0.000000	0	70.01
70.02	07002	SLEEP LAB	0.152267	5,595	70.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.320879	27,307,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.718641	18,322,739	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213859	50,666,846	73.00
74.00	07400	RENAL DIALYSIS	0.126428	3,451,835	74.00
76.97	07697	CARDIAC REHABILITATION	0.541999	124,542	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.269023	349,698	90.00
90.01	09001	DAY REHAB	0.204125	0	90.01
90.02	09002	IMAGING CENTERS	0.119227	99,849	90.02
90.03	09003	COUMADIN CLINIC	0.270491	2,508	90.03
90.04	09004	WOUND CLINIC	0.101675	66,815	90.04
90.05	09005	CARDIOVASCULAR IMAGING CENTERS	0.075802	186,514	90.05
91.00	09100	EMERGENCY	0.103114	19,740,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.496664	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		358,988,675	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)		358,988,675	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		8,802,278		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.137028	0	0	50.00
50.01	05001 GAMMA KNIFE	0.253982	0	0	50.01
50.02	03330 ENDOSCOPY	0.087046	0	0	50.02
51.00	05100 RECOVERY ROOM	0.134841	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.456311	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.039614	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.122164	138,081	16,869	54.00
54.01	03630 ULTRA SOUND	0.087615	42,476	3,722	54.01
54.02	05401 PET SCAN	0.037021	0	0	54.02
54.03	03480 ONCOLOGY	0.076900	0	0	54.03
54.04	03440 MAMMOGRAPHY	0.143769	0	0	54.04
56.00	05600 RADIOISOTOPE	0.062537	4,697	294	56.00
57.00	05700 CT SCAN	0.039179	293,318	11,492	57.00
58.00	05800 MRI	0.069613	22,737	1,583	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.110098	0	0	59.00
60.00	06000 LABORATORY	0.082964	1,721,610	142,832	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.335630	770	258	63.00
64.00	06400 INTRAVENOUS THERAPY	0.824733	1,066	879	64.00
65.00	06500 RESPIRATORY THERAPY	0.095755	78,547	7,521	65.00
66.00	06600 PHYSICAL THERAPY	0.057794	0	0	66.00
66.01	06601 REHAB OUTPATIENT	0.281957	0	0	66.01
66.02	06602 REHAB MED SURGICAL	0.188210	227,033	42,730	66.02
69.00	06900 ELECTROCARDIOLOGY	0.050510	135,754	6,857	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.133255	1,486	198	70.00
70.01	07001 NEUROLOG	0.000000	0	0	70.01
70.02	07002 SLEEP LAB	0.152267	0	0	70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.320879	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.718641	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213859	1,068,976	228,610	73.00
74.00	07400 RENAL DIALYSIS	0.126428	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.541999	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRIPTY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.269023	1,472	396	90.00
90.01	09001 DAY REHAB	0.204125	0	0	90.01
90.02	09002 IMAGING CENTERS	0.119227	0	0	90.02
90.03	09003 COUMADIN CLINIC	0.270491	0	0	90.03
90.04	09004 WOUND CLINIC	0.101675	0	0	90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	0.075802	0	0	90.05
91.00	09100 EMERGENCY	0.103114	513,409	52,940	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.496664	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,251,432	517,181	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)		4,251,432		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		32,971,087		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.137028	19,868	2,722	50.00
50.01	05001 GAMMA KNIFE	0.253982	0	0	50.01
50.02	03330 ENDOSCOPY	0.087046	119,255	10,381	50.02
51.00	05100 RECOVERY ROOM	0.134841	4,917	663	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.456311	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.039614	3,775	150	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.122164	402,378	49,156	54.00
54.01	03630 ULTRA SOUND	0.087615	386,289	33,845	54.01
54.02	05401 PET SCAN	0.037021	0	0	54.02
54.03	03480 ONCOLOGY	0.076900	264,994	20,378	54.03
54.04	03440 MAMMOGRAPHY	0.143769	0	0	54.04
56.00	05600 RADIOISOTOPE	0.062537	72,909	4,560	56.00
57.00	05700 CT SCAN	0.039179	512,165	20,066	57.00
58.00	05800 MRI	0.069613	161,937	11,273	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.110098	169,808	18,696	59.00
60.00	06000 LABORATORY	0.082964	5,721,421	474,672	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.335630	71,639	24,044	63.00
64.00	06400 INTRAVENOUS THERAPY	0.824733	42,542	35,086	64.00
65.00	06500 RESPIRATORY THERAPY	0.095755	1,604,296	153,619	65.00
66.00	06600 PHYSICAL THERAPY	0.057794	22,514,689	1,301,214	66.00
66.01	06601 REHAB OUTPATIENT	0.281957	0	0	66.01
66.02	06602 REHAB MED SURGICAL	0.188210	7,437	1,400	66.02
69.00	06900 ELECTROCARDIOLOGY	0.050510	121,211	6,122	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.133255	11,552	1,539	70.00
70.01	07001 NEUROLOG	0.000000	0	0	70.01
70.02	07002 SLEEP LAB	0.152267	0	0	70.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.320879	141,923	45,540	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.718641	11,840	8,509	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213859	5,962,575	1,275,150	73.00
74.00	07400 RENAL DIALYSIS	0.126428	795,983	100,635	74.00
76.97	07697 CARDIAC REHABILITATION	0.541999	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRIPTY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.269023	18,408	4,952	90.00
90.01	09001 DAY REHAB	0.204125	0	0	90.01
90.02	09002 IMAGING CENTERS	0.119227	0	0	90.02
90.03	09003 COUMADIN CLINIC	0.270491	0	0	90.03
90.04	09004 WOUND CLINIC	0.101675	0	0	90.04
90.05	09005 CARDIOVASCULAR IMAGING CENTERS	0.075802	4,587	348	90.05
91.00	09100 EMERGENCY	0.103114	43,761	4,512	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.496664	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		39,192,159	3,609,232	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)		39,192,159		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		17,488,001	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		52,464,002	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		3,644,655	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)		249.00	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.52	30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.47	31.00
32.00	Sum of lines 30 and 31		18.99	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.09	33.00
34.00	Disproportionate share adjustment (see instructions)		890,140	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		6,406,145,534	5,977,483,147	35.00
35.01	Factor 3 (see instructions)		0.000366391	0.000424151	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,347,155	2,535,357	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		589,995	1,896,308	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,486,303		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		76,973,101		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)			76,973,101	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			6,107,623	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			52,408	53.00
54.00	Special add-on payments for new technologies			21,518	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).			250,712	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)			83,405,362	59.00
60.00	Primary payer payments			402,342	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			83,003,020	61.00
62.00	Deductibles billed to program beneficiaries			6,284,012	62.00
63.00	Coinsurance billed to program beneficiaries			371,791	63.00
64.00	Allowable bad debts (see instructions)			943,565	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			613,317	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			665,787	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			76,960,534	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 PSR ADJUSTMENTS			0	70.00
70.50	RURAL DEMONSTRATION PROJECT			0	70.50
70.88	SCH or MDH volume decrease adjustment			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			517,550	70.93
70.94	HRR adjustment amount (see instructions)			-523,132	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			76,954,952	71.00
71.01	Sequestration adjustment (see instructions)			1,539,099	71.01
72.00	Interim payments			75,265,398	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			150,455	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0258

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2017 11:23 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	17,488,001	0	15,020,889		15,020,889	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	52,464,002	0		62,922,553	62,922,553	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,644,655	0	0	4,948,476	4,948,476	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0509	0.0509	0.0509	0.0509		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	890,140	0	191,141	698,999	890,140	11.00
11.01	Uncompensated care payments	36.00	2,486,303	0	2,527,268	0	2,527,268	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	76,973,101	0	17,739,298	59,233,803	76,973,101	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	76,973,101	0	17,739,298	59,233,803	76,973,101	15.00
16.00	Payment for inpatient program capital	50.00	6,107,623	0	0	6,107,623	6,107,623	16.00
17.00	Special add-on payments for new technologies	54.00	21,518	0	0	29,922	29,922	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0258

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2017 11:23 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	17,739,298	65,371,348	83,110,646	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	5,649,820	0	0	5,649,820	5,649,820	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	235,765	0	0	235,765	235,765	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	0.0000	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0393	0.0393	0.0393	0.0393	0.0393	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	222,038	0	0	222,038	222,038	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,107,623	0	0	6,107,623	6,107,623	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	17,488,001	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	52,464,002		62,922,553	62,922,553	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	3,644,655	0	4,948,476	4,948,476	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0509	0.0509	0.0509		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	890,140	0	890,140	890,140	11.00
11.01	Uncompensated care payments	36.00	2,486,303	589,995	1,896,308	2,486,303	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	76,973,101	589,995	76,383,106	76,973,101	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	76,973,101	589,995	76,383,106	76,973,101	15.00
16.00	Payment for inpatient program capital	50.00	6,107,623	0	6,107,623	6,107,623	16.00
17.00	Special add-on payments for new technologies	54.00	21,518	0	21,518	21,518	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			589,995	82,512,247	83,102,242	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Hospital	PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	5,649,820	0	5,649,820	5,649,820	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	235,765	0	235,765	235,765	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0393	0.0393	0.0393		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	222,038	0	222,038	222,038	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,107,623	0	6,107,623	6,107,623	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	517,550	0	517,550	517,550	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-523,132	0	-523,132	-523,132	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		15,001	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		43,085,667	2.00
3.00	PPS payments		44,908,023	3.00
4.00	Outlier payment (see instructions)		92,505	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		4,446	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		15,001	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		92,122	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)		92,122	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)		92,122	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		77,121	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		15,001	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		45,004,974	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		7,959	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		7,891,282	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)		37,120,734	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)		37,120,734	30.00
31.00	Primary payer payments		98,092	31.00
32.00	Subtotal (line 30 minus line 31)		37,022,642	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)		777,766	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		505,548	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		587,283	36.00
37.00	Subtotal (see instructions)		37,528,190	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-2,495	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		68,020	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		37,530,685	40.00
40.01	Sequestration adjustment (see instructions)		750,614	40.01
41.00	Interim payments		36,992,742	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-212,671	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: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Subprovider - IPF	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)			1,081 2.00
3.00	PPS payments			839 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			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 (line 11 minus line 20) (for CAH 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, 8 and 9)			839 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)			247 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)			592 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)			592 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			592 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)			592 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
39.98	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)			592 40.00
40.01	Sequestration adjustment (see instructions)			12 40.01
41.00	Interim payments			580 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)			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: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Subprovider - IRF	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)		1,526	2.00
3.00	PPS payments		1,822	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		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 (line 11 minus line 20) (for CAH 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, 8 and 9)		1,822	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)		450	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)		1,372	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)		1,372	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,372	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)		1,372	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
39.98	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)		1,372	40.00
40.01	Sequestration adjustment (see instructions)		27	40.01
41.00	Interim payments		1,345	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)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0258		Period: From 07/01/2016 To 06/30/2017		Worksheet E-1 Part I Date/Time Prepared: 11/30/2017 11:23 am	
		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		74,336,964		36,272,941	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		900,734		719,801	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	01/13/2017	27,700		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)		27,700		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)		75,265,398		36,992,742	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		150,455		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		212,671	6.02	
7.00	Total Medicare program liability (see instructions)		75,415,853		36,780,071	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: 14-0258
Component CCN: 14-S258

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

Worksheet E-1
Part I
Date/Time Prepared:
11/30/2017 11:23 am
PPS

Title XVIII

Subprovider -
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		3,647,925		580	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)		3,647,925		580	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		28,021		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,675,946		580	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: 14-0258
Component CCN: 14-T258

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

Worksheet E-1
Part I
Date/Time Prepared:
11/30/2017 11:23 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		22,178,778		1,345	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		22,178,778		1,345	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		42,685		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		22,221,463		1,345	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: 14-0258

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

Worksheet E-1
Part II
Date/Time Prepared:
11/30/2017 11:23 am

		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			16,135 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			36,948 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			7,467 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			73,783 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			2,147,490,607 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			20,178,709 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			759,200 8.00
9.00	Sequestration adjustment amount (see instructions)			15,184 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			744,016 10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			725,962 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			18,054 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258 Component CCN: 14-S258	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part II Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			3,918,322 1.00
2.00	Net IPF PPS Outlier Payments			11,071 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			14.975342 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			3,929,393 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			971 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			3,930,364 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			3,930,364 18.00
19.00	Deductibles			174,356 19.00
20.00	Subtotal (line 18 minus line 19)			3,756,008 20.00
21.00	Coinurance			32,662 21.00
22.00	Subtotal (line 20 minus line 21)			3,723,346 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			3,723,346 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			27,619 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			3,750,965 31.00
31.01	Sequestration adjustment (see instructions)			75,019 31.01
32.00	Interim payments			3,647,925 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			28,021 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			11,071 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part III Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			20,666,375 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0137 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			438,127 3.00
4.00	Outlier Payments			1,813,763 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			58.786301 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			22,918,265 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			22,918,265 17.00
18.00	Primary payer payments			41,670 18.00
19.00	Subtotal (line 17 less line 18).			22,876,595 19.00
20.00	Deductibles			51,940 20.00
21.00	Subtotal (line 19 minus line 20)			22,824,655 21.00
22.00	Coinurance			254,520 22.00
23.00	Subtotal (line 21 minus line 22)			22,570,135 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			22,570,135 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			104,827 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			22,674,962 32.00
32.01	Sequestration adjustment (see instructions)			453,499 32.01
33.00	Interim payments			22,178,778 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			42,685 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			1,813,763 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2017 11:23 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		5,603,224		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,603,224	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,603,224	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		5,603,224	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		5,603,224	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258 Component CCN: 14-T258	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2017 11:23 am
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital /SNF/NF services	349,199		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	349,199	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	349,199	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	349,199	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	349,199	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-0258

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

Worksheet G

Date/Time Prepared:
11/30/2017 11:23 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	43,000	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	80,749,000	0	0	0	4.00
5.00	Other receivable	2,365,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	8,700,000	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	23,522,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	115,379,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	10,100,000	0	0	0	12.00
13.00	Land improvements	901,000	0	0	0	13.00
14.00	Accumulated depreciation	-432,000	0	0	0	14.00
15.00	Buildings	180,318,000	0	0	0	15.00
16.00	Accumulated depreciation	-37,489,000	0	0	0	16.00
17.00	Leasehold improvements	2,119,000	0	0	0	17.00
18.00	Accumulated depreciation	-667,000	0	0	0	18.00
19.00	Fixed equipment	19,765,000	0	0	0	19.00
20.00	Accumulated depreciation	-4,413,000	0	0	0	20.00
21.00	Automobiles and trucks	304,000	0	0	0	21.00
22.00	Accumulated depreciation	-195,000	0	0	0	22.00
23.00	Major movable equipment	67,554,000	0	0	0	23.00
24.00	Accumulated depreciation	-40,819,000	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	4,290,000	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	201,336,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	14,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	316,729,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	71,888,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	54,549,000	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	76,029,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	202,466,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,728,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,728,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	205,194,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	111,535,000	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	111,535,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	316,729,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0258

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

Worksheet G-1

Date/Time Prepared:
11/30/2017 11:23 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		161,195,000		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		36,915,000				2.00
3.00	Total (sum of line 1 and line 2)		198,110,000		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		198,110,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFER TO AFFILIATES	86,575,000		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		86,575,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		111,535,000		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	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFER TO AFFILIATES		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: 14-0258

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	182,928,000		182,928,000	1.00
2.00	SUBPROVIDER - IPF	11,860,000		11,860,000	2.00
3.00	SUBPROVIDER - IRF	48,273,000		48,273,000	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	243,061,000		243,061,000	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	46,456,000		46,456,000	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	46,456,000		46,456,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	289,517,000		289,517,000	17.00
18.00	Ancillary services	798,765,000	0	798,765,000	18.00
19.00	Outpatient services	0	1,042,293,000	1,042,293,000	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		10,997,000	10,997,000	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	7,744,000	0	7,744,000	26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	PHYSICIAN	84,000	8,000	92,000	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,096,110,000	1,053,298,000	2,149,408,000	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		452,803,841		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ROUNDING	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)		452,803,841		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet G-3 Date/Time Prepared: 11/30/2017 11:23 am
		1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,149,408,000		1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,677,738,000		2.00
3.00	Net patient revenues (line 1 minus line 2)	471,670,000		3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	452,803,841		4.00
5.00	Net income from service to patients (line 3 minus line 4)	18,866,159		5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc	3,000		6.00
7.00	Income from investments	210,000		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	2,008,000		14.00
15.00	Revenue from rental of living quarters	0		15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0		16.00
17.00	Revenue from sale of drugs to other than patients	0		17.00
18.00	Revenue from sale of medical records and abstracts	0		18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0		19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	317,000		20.00
21.00	Rental of vending machines	0		21.00
22.00	Rental of hospital space	0		22.00
23.00	Governmental appropriations	0		23.00
24.00	CAPITATION	883,000		24.00
24.01	NET ASSETS RELEASED FROM RESTRICTIO	234,000		24.01
24.02	REFERENCE LAB	1,093,000		24.02
24.03	MEANINGFUL USE	1,532,000		24.03
24.04	OTHER INCOME	0		24.04
24.05	INTERCOMPANY LAB	3,127,000		24.05
24.06	INTERCOMPANY RENT	1,553,000		24.06
24.07		0		24.07
24.08		0		24.08
24.09		0		24.09
24.10		0		24.10
24.11	OUTPATIENT PHARMACY	5,240,000		24.11
24.12	MISC INCOME	1,393,000		24.12
24.13		0		24.13
24.14	ANSWERING SERVICE	461,000		24.14
24.15		0		24.15
25.00	Total other income (sum of lines 6-24)	18,054,000		25.00
26.00	Total (line 5 plus line 25)	36,920,159		26.00
27.00	NON RECURRING EXPENSES	5,159		27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,159		28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	36,915,000		29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet H

HHA CCN: 14-7583

To 06/30/2017

Date/Time Prepared: 11/30/2017 11:23 am

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures		0		119,500	119,500	1.00	
2.00	Capital Related - Movable Equipment		0		187,747	187,747	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	2,004,584	146,076	176,503	88,779	101,721	2,517,663	5.00
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	2,129,205	155,157	0	0	2,284,362	6.00	
7.00	Physical Therapy	1,810,617	131,941	0	0	1,942,558	7.00	
8.00	Occupational Therapy	542,304	39,518	0	0	581,822	8.00	
9.00	Speech Pathology	115,437	8,412	0	0	123,849	9.00	
10.00	Medical Social Services	71,259	5,193	0	0	76,452	10.00	
11.00	Home Health Aide	192,768	14,047	0	0	206,815	11.00	
12.00	Supplies (see instructions)	0	0	0	353,053	353,053	12.00	
13.00	Drugs	0	0	0	30,769	30,769	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Tel emedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	6,866,174	500,344	176,503	88,779	792,790	8,424,590	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)				
	7.00	8.00	9.00	10.00				
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	119,500	0	119,500		1.00	
2.00	Capital Related - Movable Equipment	0	187,747	0	187,747		2.00	
3.00	Plant Operation & Maintenance	0	0	0	0		3.00	
4.00	Transportation	0	0	0	0		4.00	
5.00	Administrative and General	0	2,517,663	0	2,517,663		5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	2,284,362	0	2,284,362		6.00	
7.00	Physical Therapy	0	1,942,558	0	1,942,558		7.00	
8.00	Occupational Therapy	0	581,822	0	581,822		8.00	
9.00	Speech Pathology	0	123,849	0	123,849		9.00	
10.00	Medical Social Services	0	76,452	0	76,452		10.00	
11.00	Home Health Aide	0	206,815	0	206,815		11.00	
12.00	Supplies (see instructions)	-237,741	115,312	0	115,312		12.00	
13.00	Drugs	0	30,769	0	30,769		13.00	
14.00	DME	0	0	0	0		14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0		15.00	
16.00	Respiratory Therapy	0	0	0	0		16.00	
17.00	Private Duty Nursing	0	0	0	0		17.00	
18.00	Clinic	0	0	0	0		18.00	
19.00	Health Promotion Activities	0	0	0	0		19.00	
20.00	Day Care Program	0	0	0	0		20.00	
21.00	Home Delivered Meals Program	0	0	0	0		21.00	
22.00	Homemaker Service	0	0	0	0		22.00	
23.00	All Others (specify)	0	0	0	0		23.00	
23.50	Tel emedicine	0	0	0	0		23.50	
24.00	Total (sum of lines 1-23)	-237,741	8,186,849	0	8,186,849		24.00	

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet H-1 Part I Date/Time Prepared: 11/30/2017 11:23 am
		HHA CCN: 14-7583	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (col s. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
	0	1.00	2.00	3.00	4.00	4A.00		
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	119,500	119,500			0	1.00	
2.00	Capital Related - Movable Equipment	187,747		187,747		0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	2,517,663	119,500	187,747	0	0	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	2,284,362	0	0	0	0	6.00	
7.00	Physical Therapy	1,942,558	0	0	0	0	7.00	
8.00	Occupational Therapy	581,822	0	0	0	0	8.00	
9.00	Speech Pathology	123,849	0	0	0	0	9.00	
10.00	Medical Social Services	76,452	0	0	0	0	10.00	
11.00	Home Health Aide	206,815	0	0	0	0	11.00	
12.00	Supplies (see instructions)	115,312	0	0	0	0	12.00	
13.00	Drugs	30,769	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
23.50	Tel emedicine	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	8,186,849	119,500	187,747	0	0	24.00	
		Administrative & General	Total (col s. 4A + 5)					
		5.00	6.00					

GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	2,824,910					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,447,586	3,731,948				6.00
7.00	Physical Therapy	858,549	2,801,107				7.00
8.00	Occupational Therapy	280,300	862,122				8.00
9.00	Speech Pathology	35,077	158,926				9.00
10.00	Medical Social Services	30,940	107,392				10.00
11.00	Home Health Aide	126,649	333,464				11.00
12.00	Supplies (see instructions)	28,931	144,243				12.00
13.00	Drugs	16,878	47,647				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	0	0				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		8,186,849				24.00

COST ALLOCATION - HHA STATISTICAL BASIS		Provider CCN: 14-0258	Period: From 07/01/2016	Worksheet H-1
		HHA CCN: 14-7583	To 06/30/2017	Part II
				Date/Time Prepared: 11/30/2017 11:23 am
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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	100			0		1.00
2.00	Capital Related - Movable Equipment		100		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	100	100	0	0	-2,824,910	5,150,009
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	354,691	2,639,053
7.00	Physical Therapy	0	0	0	0	-377,363	1,565,195
8.00	Occupational Therapy	0	0	0	0	-70,816	511,006
9.00	Speech Pathology	0	0	0	0	-59,902	63,947
10.00	Medical Social Services	0	0	0	0	-20,047	56,405
11.00	Home Health Aide	0	0	0	0	24,076	230,891
12.00	Supplies (see instructions)	0	0	0	0	-62,569	52,743
13.00	Drugs	0	0	0	0	0	30,769
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	100	100	0	0	-3,036,840	5,150,009
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	119,500	187,747	0	0		2,824,910
26.00	Unit Cost Multiplier	1,195.000000	1,877.470000	0.000000	0.000000		0.548525

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet H-2

HHA CCN: 14-7583

To 06/30/2017

Part I
Date/Time Prepared: 11/30/2017 11:23 am

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	0	0	331,729	49,981	0	1.00
2.00 Skilled Nursing Care	3,731,948	0	0	352,352	0	0	2.00
3.00 Physical Therapy	2,801,107	0	0	299,630	0	0	3.00
4.00 Occupational Therapy	862,122	0	0	89,743	0	0	4.00
5.00 Speech Pathology	158,926	0	0	19,103	0	0	5.00
6.00 Medical Social Services	107,392	0	0	11,792	0	0	6.00
7.00 Home Health Aide	333,464	0	0	31,900	0	0	7.00
8.00 Supplies (see instructions)	144,243	0	0	0	0	0	8.00
9.00 Drugs	47,647	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	8,186,849	0	0	1,136,249	49,981	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/AC COUNTS RECEIVABLE	Subtotal	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	
	5.03	5.04	5.05	5A.05	5.06	6.00	
1.00 Administrative and General	4,826	0	0	386,536	93,707	0	1.00
2.00 Skilled Nursing Care	0	0	0	4,084,300	1,184,461	0	2.00
3.00 Physical Therapy	0	0	0	3,100,737	702,492	0	3.00
4.00 Occupational Therapy	0	0	0	951,865	229,350	0	4.00
5.00 Speech Pathology	0	0	0	178,029	28,701	0	5.00
6.00 Medical Social Services	0	0	0	119,184	25,316	0	6.00
7.00 Home Health Aide	0	0	0	365,364	103,628	0	7.00
8.00 Supplies (see instructions)	0	0	0	144,243	21,293	0	8.00
9.00 Drugs	0	0	0	47,647	13,306	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19) (2)	4,826	0	0	9,377,905	2,402,254	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.000000			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet H-2

HHA CCN: 14-7583

To 06/30/2017

Part I
Date/Time Prepared:
11/30/2017 11:23 am

Home Health
Agency I

PPS

Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	6,550	0	0	0	0	486,793	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	5,268,761	2.00
3.00	Physical Therapy	0	0	0	0	0	3,803,229	3.00
4.00	Occupational Therapy	0	0	0	0	0	1,181,215	4.00
5.00	Speech Pathology	0	0	0	0	0	206,730	5.00
6.00	Medical Social Services	0	0	0	0	0	144,500	6.00
7.00	Home Health Aide	0	0	0	0	0	468,992	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	165,536	8.00
9.00	Drugs	0	0	0	0	0	60,953	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	6,550	0	0	0	0	11,786,709	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet H-2

HHA CCN: 14-7583

To 06/30/2017

Part I
Date/Time Prepared:
11/30/2017 11:23 am

Home Health Agency I

PPS

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General	0	486,793				1.00
2.00 Skilled Nursing Care	0	5,268,761	226,976	5,495,737		2.00
3.00 Physical Therapy	0	3,803,229	163,839	3,967,068		3.00
4.00 Occupational Therapy	0	1,181,215	50,886	1,232,101		4.00
5.00 Speech Pathology	0	206,730	8,906	215,636		5.00
6.00 Medical Social Services	0	144,500	6,225	150,725		6.00
7.00 Home Health Aide	0	468,992	20,204	489,196		7.00
8.00 Supplies (see instructions)	0	165,536	7,131	172,667		8.00
9.00 Drugs	0	60,953	2,626	63,579		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19) (2)	0	11,786,709	486,793	11,786,709		20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.043079			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0258 HHA CCN: 14-7583	Period: From 07/01/2016 To 06/30/2017	Worksheet H-2 Part II Date/Time Prepared: 11/30/2017 11:23 am PPS
		Home Health Agency I	

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NO OF PHONES)	DATA PROCESSING (DATA PROCESSING)	PURCHASING RECEIVING AND STORES (PURCHASING)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DEPREC EXPENSE)					
	1.00	2.00					
1.00 Administrative and General	0	0	2,004,584	98	0	66,891	1.00
2.00 Skilled Nursing Care	0	0	2,129,205	0	0	0	2.00
3.00 Physical Therapy	0	0	1,810,617	0	0	0	3.00
4.00 Occupational Therapy	0	0	542,304	0	0	0	4.00
5.00 Speech Pathology	0	0	115,437	0	0	0	5.00
6.00 Medical Social Services	0	0	71,259	0	0	0	6.00
7.00 Home Health Aide	0	0	192,769	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	0	6,866,175	98	0	66,891	20.00
21.00 Total cost to be allocated	0	0	1,136,249	49,981	0	4,826	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.165485	510.010204	0.000000	0.072147	22.00
Cost Center Description	ADMINISTRATIVE AND GENERAL (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
	5.04	5.05	5A.06	5.06	6.00	7.00	
1.00 Administrative and General	0	0	-50,971	335,565	0	0	1.00
2.00 Skilled Nursing Care	0	0	157,249	4,241,549	0	0	2.00
3.00 Physical Therapy	0	0	-585,118	2,515,619	0	0	3.00
4.00 Occupational Therapy	0	0	-130,564	821,301	0	0	4.00
5.00 Speech Pathology	0	0	-75,252	102,777	0	0	5.00
6.00 Medical Social Services	0	0	-28,528	90,656	0	0	6.00
7.00 Home Health Aide	0	0	5,729	371,093	0	0	7.00
8.00 Supplies (see instructions)	0	0	-67,994	76,249	0	0	8.00
9.00 Drugs	0	0	0	47,647	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	0	0	0	8,602,456	0	0	20.00
21.00 Total cost to be allocated	0	0	0	2,402,254	0	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0	0.279252	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 14-0258 HHA CCN: 14-7583	Period: From 07/01/2016 To 06/30/2017	Worksheet H-2 Part II Date/Time Prepared: 11/30/2017 11:23 am
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		Home Health Agency I				PPS		
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	0	125,041	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Tel emedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	0	125,041	20.00
21.00	Total cost to be allocated	0	0	0	0	0	6,550	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.052383	22.00
Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	PARAMED ED PRGM (PATIENT DAYS)			
		15.00	16.00	17.00	23.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Tel emedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet H-3 Part I Date/Time Prepared: 11/30/2017 11:23 am
		HHA CCN: 14-7583		

			Title XVIII	Home Health Agency I	PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	5,495,737		5,495,737	24,920	220.54	1.00
2.00	Physical Therapy	3.00	3,967,068	0	3,967,068	20,422	194.25	2.00
3.00	Occupational Therapy	4.00	1,232,101	0	1,232,101	6,665	184.86	3.00
4.00	Speech Pathology	5.00	215,636	0	215,636	1,255	171.82	4.00
5.00	Medical Social Services	6.00	150,725		150,725	743	202.86	5.00
6.00	Home Health Aide	7.00	489,196		489,196	4,790	102.13	6.00
7.00	Total (sum of lines 1-6)		11,550,463	0	11,550,463	58,795		7.00

		Program Visits				
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Part B		
				Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
	0	1.00	2.00	3.00	4.00	5.00

Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	17,812		8.00
8.01	Skilled Nursing Care		20994	0	344		8.01
8.02	Skilled Nursing Care		29404	0	86		8.02
9.00	Physical Therapy		16974	0	14,111		9.00
9.01	Physical Therapy		20994	0	214		9.01
9.02	Physical Therapy		29404	0	53		9.02
10.00	Occupational Therapy		16974	0	4,857		10.00
10.01	Occupational Therapy		20994	0	62		10.01
10.02	Occupational Therapy		29404	0	24		10.02
11.00	Speech Pathology		16974	0	761		11.00
11.01	Speech Pathology		20994	0	16		11.01
11.02	Speech Pathology		29404	0	0		11.02
12.00	Medical Social Services		16974	0	541		12.00
12.01	Medical Social Services		20994	0	10		12.01
12.02	Medical Social Services		29404	0	3		12.02
13.00	Home Health Aide		16974	0	3,972		13.00
13.01	Home Health Aide		20994	0	34		13.01
13.02	Home Health Aide		29404	0	7		13.02
14.00	Total (sum of lines 8-13)			0	42,907		14.00

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
	0	1.00	2.00	3.00	4.00	5.00

Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	172,667	0	172,667	329,631	0.523819	15.00
16.00	Cost of Drugs	9.00	63,579	0	63,579	0	0.000000	16.00

		Program Visits			Cost of Services	
Cost Center Description	Part A	Part B		Part A		Part B
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	18,242		0	4,023,091	1.00
2.00	Physical Therapy	0	14,378		0	2,792,927	2.00
3.00	Occupational Therapy	0	4,943		0	913,763	3.00
4.00	Speech Pathology	0	777		0	133,504	4.00
5.00	Medical Social Services	0	554		0	112,384	5.00
6.00	Home Health Aide	0	4,013		0	409,848	6.00
7.00	Total (sum of lines 1-6)	0	42,907		0	8,385,517	7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0258 HHA CCN: 14-7583	Period: From 07/01/2016 To 06/30/2017	Worksheet H-3 Part I Date/Time Prepared: 11/30/2017 11:23 am
				Title XVIII	Home Health Agency I	PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
8.02	Skilled Nursing Care						8.02
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
9.02	Physical Therapy						9.02
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
10.02	Occupational Therapy						10.02
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
11.02	Speech Pathology						11.02
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
12.02	Medical Social Services						12.02
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
13.02	Home Health Aide						13.02
14.00	Total (sum of lines 8-13)						14.00
		Program Covered Charges			Cost of Services		
Cost Center Description		Part A	Part B		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		6.00	7.00	8.00	9.00	10.00	11.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	296,166	0	0	155,137	0
16.00	Cost of Drugs		0	0		0	0
Cost Center Description		Total Program Cost (sum of col.s. 9-10)					
		12.00					
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	4,023,091					1.00
2.00	Physical Therapy	2,792,927					2.00
3.00	Occupational Therapy	913,763					3.00
4.00	Speech Pathology	133,504					4.00
5.00	Medical Social Services	112,384					5.00
6.00	Home Health Aide	409,848					6.00
7.00	Total (sum of lines 1-6)	8,385,517					7.00
Cost Center Description							
		12.00					
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
8.01	Skilled Nursing Care						8.01
8.02	Skilled Nursing Care						8.02
9.00	Physical Therapy						9.00
9.01	Physical Therapy						9.01
9.02	Physical Therapy						9.02
10.00	Occupational Therapy						10.00
10.01	Occupational Therapy						10.01
10.02	Occupational Therapy						10.02
11.00	Speech Pathology						11.00
11.01	Speech Pathology						11.01
11.02	Speech Pathology						11.02
12.00	Medical Social Services						12.00
12.01	Medical Social Services						12.01
12.02	Medical Social Services						12.02
13.00	Home Health Aide						13.00
13.01	Home Health Aide						13.01
13.02	Home Health Aide						13.02
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 14-0258 HHA CCN: 14-7583	Period: From 07/01/2016 To 06/30/2017	Worksheet H-3 Part II Date/Time Prepared: 11/30/2017 11:23 am
Title XVIII			Home Health Agency I	PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.057794	0	0	col. 2, line 2.00
1.01	Physical Therapy 1	66.01	0.281957	0	0	col. 2, line 2.01
1.02	Physical Therapy 2	66.02	0.188210	0	0	col. 2, line 2.02
2.00	Occupational Therapy					
3.00	Speech Pathology					
4.00	Cost of Medical Supplies	71.00	0.320879	0	0	col. 2, line 15.00
5.00	Cost of Drugs	73.00	0.213859	0	0	col. 2, line 16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0258 HHA CCN: 14-7583	Period: From 07/01/2016 To 06/30/2017	Worksheet H-4 Part I-II Date/Time Prepared: 11/30/2017 11:23 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	7,902,424
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	150,677
13.00	Total PPS Reimbursement - LUPA Episodes		0	163,446
14.00	Total PPS Reimbursement - PEP Episodes		0	97,529
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	13,167
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	6,912
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	8,334,155
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	8,334,155
25.00	Coinurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	8,334,155
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	8,334,155
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	8,334,155
31.01	Sequestration adjustment (see instructions)		0	166,560
32.00	Interim payments (see instructions)		0	8,161,461
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	6,134
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet H-5
	HHA CCN: 14-7583	Home Health Agency I	Date/Time Prepared: 11/30/2017 11:23 am 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		0		8,161,461	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			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			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. H-4, Part II, column as appropriate, line 32)		0		8,161,461	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			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		6,134	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		8,167,595	7.00
		0		Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN: 14-0258 Hospice CCN: 14-1632		Period: From 07/01/2016 To 06/30/2017		Worksheet 0 Date/Time Prepared: 11/30/2017 11:23 am	
		Hospice I					
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT*		199,734	199,734	-75,610	124,124	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		155,257	155,257	-18,698	136,559	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	272,108	272,108	0	272,108	3.00
4.00	ADMINISTRATIVE & GENERAL*	667,522	649,539	1,317,061	0	1,317,061	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	193,142	193,142	0	193,142	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	5,027	5,027	0	5,027	6.00
7.00	HOUSEKEEPING*	0	109,950	109,950	0	109,950	7.00
8.00	DIETARY*	0	21,592	21,592	0	21,592	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	179,352	179,352	-173,800	5,552	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	61,453	61,453	0	61,453	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	13,537	973	14,510	0	14,510	13.00
14.00	PHARMACY*	0	126,706	126,706	0	126,706	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	334,272	334,272	0	334,272	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	1,968,857	0	1,968,857	0	1,968,857	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	3,447	0	3,447	0	3,447	30.00
31.00	OCCUPATIONAL THERAPY**	2,595	0	2,595	0	2,595	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	298,853	0	298,853	0	298,853	33.00
34.00	SPIRITUAL COUNSELING**	205,277	0	205,277	0	205,277	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	625,017	0	625,017	0	625,017	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	41,384	41,384	0	41,384	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	358,625	358,625	0	358,625	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	3,785,105	2,709,114	6,494,219	-268,108	6,226,111	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet 0
		Hospice CCN: 14-1632	Date/Time Prepared: 11/30/2017 11:23 am	
		Hospice I		

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	124,124	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	136,559	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	272,108	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	1,317,061	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	193,142	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	5,027	6.00
7.00	HOUSEKEEPING*	0	109,950	7.00
8.00	DIETARY*	0	21,592	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	5,552	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	61,453	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	14,510	13.00
14.00	PHARMACY*	0	126,706	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	334,272	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	1,968,857	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	3,447	30.00
31.00	OCCUPATIONAL THERAPY**	0	2,595	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	298,853	33.00
34.00	SPIRITUAL COUNSELING**	0	205,277	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	625,017	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	41,384	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	358,625	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	6,226,111	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-1

Hospice CCN: 14-1632

To 06/30/2017

Date/Time Prepared: 11/30/2017 11:23 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED		
26.00	PHYSICIAN SERVICES	0	0
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	0
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	0
31.00	OCCUPATIONAL THERAPY	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	0
34.00	SPIRITUAL COUNSELING	0	0
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0
43.00	OUTPATIENT SERVICES	0	0
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0
100.00	TOTAL *	0	0

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE	Provider CCN: 14-0258 Hospice CCN: 14-1632	Period: From 07/01/2016 To 06/30/2017	Worksheet 0-2 Date/Time Prepared: 11/30/2017 11:23 am
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	Hospice I					
	SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
	1.00	2.00	3.00	4.00	5.00	
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED					25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	1,758,996	0	1,758,996	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	3,447	0	3,447	0	30.00
31.00	OCCUPATIONAL THERAPY	2,595	0	2,595	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	266,998	0	266,998	0	33.00
34.00	SPIRITUAL COUNSELING	183,396	0	183,396	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	558,397	0	558,397	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	41,384	41,384	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	320,399	320,399	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	2,773,829	361,783	3,135,612	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6.00	7.00	
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED		25.00
26.00	PHYSICIAN SERVICES	0	26.00
27.00	NURSE PRACTITIONER	0	27.00
28.00	REGISTERED NURSE	1,758,996	28.00
29.00	LPN/LVN	0	29.00
30.00	PHYSICAL THERAPY	3,447	30.00
31.00	OCCUPATIONAL THERAPY	2,595	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	32.00
33.00	MEDICAL SOCIAL SERVICES	266,998	33.00
34.00	SPIRITUAL COUNSELING	183,396	34.00
35.00	DIETARY COUNSELING	0	35.00
36.00	COUNSELING - OTHER	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	558,397	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	41,384	38.00
39.00	PATIENT TRANSPORTATION	0	39.00
40.00	IMAGING SERVICES	0	40.00
41.00	LABS & DIAGNOSTICS	320,399	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	42.00
43.00	OUTPATIENT SERVICES	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	46.00
100.00	TOTAL *	3,135,612	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPIRE CARE

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-3

Hospice CCN: 14-1632

To 06/30/2017

Date/Time Prepared: 11/30/2017 11:23 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	20,818	0	20,818	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	3,160	0	3,160	0	33.00
34.00	SPIRITUAL COUNSELING	2,171	0	2,171	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	6,609	0	6,609	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	3,792	3,792	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	32,758	3,792	36,550	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0
26.00	PHYSICIAN SERVICES	0	0
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	20,818
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	0
31.00	OCCUPATIONAL THERAPY	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	3,160
34.00	SPIRITUAL COUNSELING	0	2,171
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	6,609
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	3,792
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0
43.00	OUTPATIENT SERVICES	0	0
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0
100.00	TOTAL *	0	36,550

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-4

Hospice CCN: 14-1632

To 06/30/2017

Date/Time Prepared: 11/30/2017 11:23 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI - CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
DI RECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	27.00
28.00	REGISTERED NURSE	189,043	0	189,043	0	28.00
29.00	LPN/LVN	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	28,695	0	28,695	0	33.00
34.00	SPIRITUAL COUNSELING	19,710	0	19,710	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	60,011	0	60,011	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	34,434	34,434	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	46.00
100.00	TOTAL *	297,459	34,434	331,893	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)
		6.00	7.00
DI RECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED	0	0
26.00	PHYSICIAN SERVICES	0	0
27.00	NURSE PRACTITIONER	0	0
28.00	REGISTERED NURSE	0	189,043
29.00	LPN/LVN	0	0
30.00	PHYSICAL THERAPY	0	0
31.00	OCCUPATIONAL THERAPY	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0
33.00	MEDICAL SOCIAL SERVICES	0	28,695
34.00	SPIRITUAL COUNSELING	0	19,710
35.00	DIETARY COUNSELING	0	0
36.00	COUNSELING - OTHER	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	60,011
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0
39.00	PATIENT TRANSPORTATION	0	0
40.00	IMAGING SERVICES	0	0
41.00	LABS & DIAGNOSTICS	0	34,434
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0
43.00	OUTPATIENT SERVICES	0	0
44.00	PALLIATIVE RADIATION THERAPY	0	0
45.00	PALLIATIVE CHEMOTHERAPY	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0
100.00	TOTAL *	0	331,893

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-5

Hospice CCN: 14-1632

To 06/30/2017

Date/Time Prepared: 11/30/2017 11:23 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of col s. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	124,124	0	124,124	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	136,559	89,380	225,939	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	272,108	626,378	898,486	3.00
4.00	ADMINISTRATIVE & GENERAL	1,317,061	1,793,973	3,111,034	4.00
5.00	PLANT OPERATION & MAINTENANCE	193,142	0	193,142	5.00
6.00	LAUNDRY & LINEN SERVICE	5,027	0	5,027	6.00
7.00	HOUSEKEEPING	109,950	0	109,950	7.00
8.00	DIETARY	21,592	0	21,592	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	5,552	2,678	8,230	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	61,453	0	61,453	12.00
13.00	VOLUNTEER SERVICE COORDINATION	14,510	0	14,510	13.00
14.00	PHARMACY	126,706	0	126,706	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	334,272	0	334,272	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	3,135,612	0	3,135,612	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	36,550	0	36,550	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	331,893	0	331,893	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	6,226,111	2,512,409	8,738,520	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-6

Hospice CCN: 14-1632

To 06/30/2017

Part I
Date/Time Prepared:
11/30/2017 11:23 am

Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
	0	1.00	2.00	3.00	3A	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIX	124,124	124,124			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	225,939		225,939		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	898,486	0	0	898,486	3.00
4.00	ADMINISTRATIVE & GENERAL	3,111,034	0	0	0	3,111,034
5.00	PLANT OPERATION & MAINTENANCE	193,142	0	0	0	193,142
6.00	LAUNDRY & LINEN SERVICE	5,027	0	0	0	5,027
7.00	HOUSEKEEPING	109,950	0	0	0	109,950
8.00	DIETARY	21,592	0	0	0	21,592
9.00	NURSING ADMINISTRATION	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES	8,230	0	0	0	8,230
11.00	MEDICAL RECORDS	0	0	0	0	0
12.00	STAFF TRANSPORTATION	61,453	0	0	0	61,453
13.00	VOLUNTEER SERVICE COORDINATION	14,510	0	0	0	14,510
14.00	PHARMACY	126,706	0	0	0	126,706
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	334,272	0	0	0	334,272
16.00	OTHER GENERAL SERVICE	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0
51.00	HOSPICE ROUTINE HOME CARE	3,135,612			802,716	3,938,328
52.00	HOSPICE INPATIENT RESPIRE CARE	36,550	12,313	22,413	9,500	80,776
53.00	HOSPICE GENERAL INPATIENT CARE	331,893	111,811	203,526	86,270	733,500
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0
61.00	VOLUNTEER PROGRAM	0	0	0	0	0
62.00	FUNDRAISING	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0
69.00	THRIFT STORE	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD	0				0
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0	0	0	0
100.00	TOTAL	8,738,520	124,124	225,939	898,486	8,738,520

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 14-0258	Period: From 07/01/2016	Worksheet 0-6
		Hospice CCN: 14-1632	To 06/30/2017	Part I
				Date/Time Prepared: 11/30/2017 11:23 am

Descriptions	Hospice I					
	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
	4.00	5.00	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL	3,111,034				4.00
5.00	PLANT OPERATION & MAINTENANCE	106,774	299,916			5.00
6.00	LAUNDRY & LINEN SERVICE	2,779	0	7,806		6.00
7.00	HOUSEKEEPING	60,783	0		170,733	7.00
8.00	DIETARY	11,937	0		0	33,529
9.00	NURSING ADMINISTRATION	0	0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	4,550	0		0	10.00
11.00	MEDICAL RECORDS	0	0		0	11.00
12.00	STAFF TRANSPORTATION	33,973	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	8,022	0		0	13.00
14.00	PHARMACY	70,047	0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	184,795	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0				50.00
51.00	HOSPICE ROUTINE HOME CARE	2,177,220				51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	44,655	29,751	774	16,937	3,326
53.00	HOSPICE GENERAL INPATIENT CARE	405,499	270,165	7,032	153,796	30,203
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	61.00
62.00	FUNDRAISING	0	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0
67.00	ADVERTISING	0	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0	68.00
69.00	THRIFT STORE	0	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0
99.00	NEGATIVE COST CENTER	0	0		0	0
100.00	TOTAL	3,111,034	299,916	7,806	170,733	33,529

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet 0-6 Part I Date/Time Prepared: 11/30/2017 11:23 am
		Hospice CCN: 14-1632	Hospice I	

Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
	9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION	0				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	12,780			10.00
11.00	MEDICAL RECORDS	0		0		11.00
12.00	STAFF TRANSPORTATION	0			95,426	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	13.00
14.00	PHARMACY	0			0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	15.00
16.00	OTHER GENERAL SERVICE	0			0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	11,418	0	85,254	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	0	135	0	1,009	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	1,227	0	9,163	53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	60.00
61.00	VOLUNTEER PROGRAM	0			0	61.00
62.00	FUNDRAISING	0			0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	65.00
66.00	RESIDENTIAL CARE	0			0	66.00
67.00	ADVERTISING	0			0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	68.00
69.00	THRIFT STORE	0			0	69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	99.00
100.00	TOTAL	0	12,780	0	95,426	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-6

Hospice CCN: 14-1632

To 06/30/2017

Part I
Date/Time Prepared:
11/30/2017 11:23 am

Descriptions	Hospice I				TOTAL	
	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
	14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS						
1.00						1.00
2.00						2.00
3.00						3.00
4.00						4.00
5.00						5.00
6.00						6.00
7.00						7.00
8.00						8.00
9.00						9.00
10.00						10.00
11.00						11.00
12.00						12.00
13.00						13.00
14.00	196,753					14.00
15.00	0	519,067				15.00
16.00	0		0			16.00
17.00				0		17.00
LEVEL OF CARE						
50.00	0	0	0		0	50.00
51.00	175,781	463,740	0		6,871,872	51.00
52.00	2,080	5,488	0	0	185,169	52.00
53.00	18,892	49,839	0	0	1,681,479	53.00
NONREIMBURSABLE COST CENTERS						
60.00	0		0		0	60.00
61.00	0		0		0	61.00
62.00	0		0		0	62.00
63.00	0		0		0	63.00
64.00	0		0		0	64.00
65.00	0		0		0	65.00
66.00	0	0	0	0	0	66.00
67.00	0		0		0	67.00
68.00	0		0		0	68.00
69.00	0		0		0	69.00
70.00						70.00
71.00	0	0	0	0	0	71.00
99.00	0	0	0	0	0	99.00
100.00	196,753	519,067	0	0	8,738,520	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0258

Hospice CCN: 14-1632

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

Worksheet 0-6
Part 11
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Descriptions		Hospice I				ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION		
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,246					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		3,246				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	30,453			3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	0	-3,111,034	5,627,486	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	193,142	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	5,027	6.00
7.00	HOUSEKEEPING	0	0	0	0	109,950	7.00
8.00	DIETARY	0	0	0	0	21,592	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	8,230	10.00
11.00	MEDICAL RECORDS	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	61,453	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	14,510	13.00
14.00	PHARMACY	0	0	0	0	126,706	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	334,272	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			27,207	0	3,938,328	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	322	322	322	0	80,776	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,924	2,924	2,924	0	733,500	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part 1)	124,124	225,939	898,486		3,111,034	100.00
101.00	UNIT COST MULTIPLIER	38.239063	69.605360	29.504023		0.552828	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0258

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

Worksheet 0-6
Part 11
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	3,246					5.00
6.00	LAUNDRY & LINEN SERVICE	0	3,246				6.00
7.00	HOUSEKEEPING	0		3,246			7.00
8.00	DIETARY	0		0	3,246		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	322	322	322	322	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,924	2,924	2,924	2,924	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part 1)	299,916	7,806	170,733	33,529	0	100.00
101.00	UNIT COST MULTIPLIER	92.395564	2.404806	52.597967	10.329328	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-6

Hospice CCN: 14-1632

To 06/30/2017

Part II
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Descriptions		Hospice I					
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	30,453					10.00
11.00	MEDICAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION			30,453			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	30,453		13.00
14.00	PHARMACY			0	0	30,453	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	27,207	0	27,207	27,207	27,207	51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	322	0	322	322	322	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,924	0	2,924	2,924	2,924	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	12,780	0	95,426	22,532	196,753	100.00
101.00	UNIT COST MULTIPLIER	0.419663	0.000000	3.133550	0.739894	6.460874	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-6

Hospice CCN: 14-1632

To 06/30/2017

Part II
Date/Time Prepared:
11/30/2017 11:23 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	30,453				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	27,207	0			51.00
52.00	HOSPICE INPATIENT RESPIRE CARE	322	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	2,924	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	519,067	0	0		100.00
101.00	UNIT COST MULTIPLIER	17.044856	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0258

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

Worksheet 0-7

Hospice CCN: 14-1632

Date/Time Prepared: 11/30/2017 11:23 am

Cost Center Descriptions		From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)			
				HCHC	HRHC	HIRC	
				0	1.00	2.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.057794	0	0	0	1.00
1.01	REHAB OUTPATIENT	66.01	0.281957	0	0	0	1.01
1.02	REHAB MED SURGICAL	66.02	0.188210	0	0	0	1.02
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.213859	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.082964	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.320879	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.97	CARDIAC REHABILITATION	76.97	0.541999	0	0	0	10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98	0.000000	0	0	0	10.98
10.99	LI THOTRIPTY	76.99	0.000000	0	0	0	10.99
11.00	Totals (sum of lines 1-11)						11.00
Cost Center Descriptions		Charges by LOC (From Provider Records)		Shared Service Costs by LOC			
		HGIP		HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)
		5.00		6.00	7.00	8.00	9.00
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
1.01	REHAB OUTPATIENT	0	0	0	0	0	1.01
1.02	REHAB MED SURGICAL	0	0	0	0	0	1.02
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.97	CARDIAC REHABILITATION	0	0	0	0	0	10.97
10.98	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	10.98
10.99	LI THOTRIPTY	0	0	0	0	0	10.99
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0258

Period: From 07/01/2016

Worksheet 0-8

Hospice CCN: 14-1632

To 06/30/2017

Date/Time Prepared: 11/30/2017 11:23 am

		Hospice I		
		TITLE XVII MEDI CARE	TITLE XIX MEDI CAID	TOTAL
		1.00	2.00	3.00
HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			0
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0
3.00	Total average cost per diem (line 1 divided by line 2)			0.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)			
5.00	Program cost (line 3 times line 4)	0	0	0
HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			6,871,872
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			27,207
8.00	Total average cost per diem (line 6 divided by line 7)			252.58
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	24,664	1,348	
10.00	Program cost (line 8 times line 9)	6,229,633	340,478	
HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			185,169
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			322
13.00	Total average cost per diem (line 11 divided by line 12)			575.06
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	296	0	
15.00	Program cost (line 13 times line 14)	170,218	0	
HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			1,681,479
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			2,924
18.00	Total average cost per diem (line 16 divided by line 17)			575.06
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	2,357	195	
20.00	Program cost (line 18 times line 19)	1,355,416	112,137	
TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			8,738,520
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			30,453
23.00	Average cost per diem (line 21 divided by line 22)			286.95

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0258	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/30/2017 11:23 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		5,649,820	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		235,765	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)		202.15	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)		2.52	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		16.47	8.00
9.00	Sum of lines 7 and 8		18.99	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.93	10.00
11.00	Disproportionate share adjustment (see instructions)		222,038	11.00
12.00	Total prospective capital payments (see instructions)		6,107,623	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