

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: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 9:09 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.

Date: 11/28/2017 Time: 9:09 am

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.

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 GENESIS MEDICAL CENTER - SILVIS (14-0275) 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)

CFO _____
 Title _____

11/28/2017 _____
 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	34,907	-32,856	413,922	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
200.00 Total	0	34,907	-32,856	413,922	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: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 9:08 am		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 801 HOSPITAL ROAD			PO Box:				1.00		
2.00	City: SILVIS			State: IL		Zip Code: 61282-		County: ROCK ISLAND		
		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		GENESIS MEDICAL CENTER - SILVIS		140275	19340	1	07/01/1966	N P O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF		ILLINI RESTORATIVE CARE CENTER		145703	19340		09/03/1991	N P N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2016	06/30/2017	20.00	
21.00	Type of Control (see instructions)						2		21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y	N	22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y	22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N	22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N	22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							3 N	23.00	
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
				1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,340	59	0	261	105	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 9:08 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00	
		V	XVII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)	N	Y	N		45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00	
47.00	Is this a new hospital under 42 CFR 412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME					
	1.00	2.00	3.00	4.00	5.00					
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						0.00	0.00	61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count					
	1.00	2.00	3.00	4.00						
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
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)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						0.00	62.01		
Teaching Hospitals that Claim Residents in Nonprovider Settings										
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)						N	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))				
	1.00	2.00	3.00	4.00	5.00					
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.										
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	0.00	0.000000	64.00
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.										
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))				
	1.00	2.00	3.00	4.00	5.00					
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 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.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00	
				1.00			
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00	
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00	
				V	XIX		
				1.00	2.00		
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N		94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.					107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
		Physical		Speech		Respiratory	
		1.00		3.00		4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
						1.00	
						2.00	
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		0		208,474	
						1.00	
						2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 9:08 am
		Beginning 1.00	Ending 2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2016	06/30/2017	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 9:08 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	09/29/2016	Y	09/29/2016		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 9:08 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		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		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.		Y		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.	MARTIN	ORWI TZ		41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWI TZM@GENESISHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0275

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

Worksheet S-2
Part II
Date/Time Prepared:
11/28/2017 9:08 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.	DI RECTOR, REIMBURSEMENT	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: 14-0275

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 9:08 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	138	50,370	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)		138	50,370	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		145	52,925	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	92	33,580		0	19.00
20.00 NURSING FACILITY	45.00	28	10,220		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		265			0	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: 14-0275

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 9:08 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)	4,229	401	10,305			1.00
2.00 HMO and other (see instructions)	2,632	2,098				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,229	401	10,305			7.00
8.00 INTENSIVE CARE UNIT	433	29	1,070			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		237	894			13.00
14.00 Total (see instructions)	4,662	667	12,269	0.00	451.78	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	4,423	6,029	26,628	0.00	73.30	19.00
20.00 NURSING FACILITY		0	4,166	0.00	8.60	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	533.68	27.00
28.00 Observation Bed Days		433	1,127			28.00
29.00 Ambulance Trips	3,187					29.00
30.00 Employee discount days (see instruction)			155			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: 14-0275

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 9:08 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,426	1,005	4,123	1.00
2.00 HMO and other (see instructions)			799	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,426	1,005	4,123	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet S-3 Part II Date/Time Prepared: 11/28/2017 9:08 am	
	Worksheet A Line Number	Amount Reported	Reclassification 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	29,193,723	0	29,193,723	863,777.00	33.80	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		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	3,078,089	-5,826	3,072,263	152,586.00	20.13	9.00
10.00	Excluded area salaries (see instructions)		3,518,770	21,435	3,540,205	195,964.00	18.07	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		958,824	0	958,824	12,250.00	78.27	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		318,554	0	318,554	2,888.00	110.30	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		8,860,229	0	8,860,229	176,931.00	50.08	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)		4,919,103	0	4,919,103			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,478,058	0	1,478,058			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		0	0	0			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
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	4,274	0	4,274	236.00	18.11	26.00
27.00	Administrative & General	5.00	1,039,497	0	1,039,497	17,194.00	60.46	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0275

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

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2017 9:08 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	518,281	0	518,281	26,784.00	19.35	30.00
31.00	Laundry & Linen Service	8.00	51,058	-15,609	35,449	2,663.00	13.31	31.00
32.00	Housekeeping	9.00	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)		578,616	0	578,616	24,918.00	23.22	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		99,266	0	99,266	5,075.00	19.56	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	707,941	0	707,941	20,225.00	35.00	38.00
39.00	Central Services and Supply	14.00	117,106	0	117,106	8,595.00	13.62	39.00
40.00	Pharmacy	15.00	1,686,344	0	1,686,344	39,621.00	42.56	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0275

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

Worksheet S-3
Part III
Date/Time Prepared:
11/28/2017 9:08 am

	Worksheet A	Amount	Reclassifi cation	Adjusted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Salaries	Related to	Wage (col. 4 ÷	
	1.00	2.00	(from	(col. 2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	29,871,605	0	29,871,605	893,770.00	33.42	1.00
2.00	Excluded area salaries (see instructions)	6,596,859	15,609	6,612,468	348,550.00	18.97	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,274,746	-15,609	23,259,137	545,220.00	42.66	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,137,607	0	10,137,607	192,069.00	52.78	4.00
5.00	Subtotal wage-related costs (see inst.)	4,919,103	0	4,919,103	0.00	21.15	5.00
6.00	Total (sum of lines 3 thru 5)	38,331,456	-15,609	38,315,847	737,289.00	51.97	6.00
7.00	Total overhead cost (see instructions)	4,802,383	-15,609	4,786,774	145,311.00	32.94	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2017 9:08 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			373,724 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			2,242,072 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			515,782 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			163,236 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			39,711 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			112,427 14.00
15.00	'Workers' Compensation Insurance			0 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			750,596 16.00
TAXES				
17.00	FICA-Employers Portion Only			2,109,968 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			1,345 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			931 22.00
23.00	Tuition Reimbursement			87,370 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			6,397,162 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part V Date/Time Prepared: 11/28/2017 9:08 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		958,824	6,397,162
2.00	Hospital		958,824	6,397,162
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF		0	0
9.00	Hospital-Based NF		0	0
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis			
18.00	Other		0	0

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0275

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

Worksheet S-7

Date/Time Prepared:
11/28/2017 9:08 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	406	0	406	12.00
13.00		RUB	399	0	399	13.00
14.00		RUA	839	0	839	14.00
15.00		RVC	663	0	663	15.00
16.00		RVB	579	0	579	16.00
17.00		RVA	1,019	0	1,019	17.00
18.00		RHC	170	0	170	18.00
19.00		RHB	37	0	37	19.00
20.00		RHA	71	0	71	20.00
21.00		RMC	8	0	8	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	22	0	22	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	1	0	1	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	51	0	51	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	11	0	11	39.00
40.00		LD1	38	0	38	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	1	0	1	42.00
43.00		LB2	2	0	2	43.00
44.00		LB1	5	0	5	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	3	0	3	47.00
48.00		CD1	6	0	6	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	2	0	2	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	35	0	35	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	24	0	24	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	5	0	5	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0275

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

Worksheet S-7

Date/Time Prepared:
11/28/2017 9:08 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	6	0	6	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	3	0	3	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	8	0	8	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	9	0	9	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,423	0	4,423	200.00

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

201.00 SNF SERVICES
 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).
 19340 201.00

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

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

202.00	Staffing	3,076,689	43.03	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	2,807	0.04	Y	204.00
205.00	Training	850	0.01	Y	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	7,150,616			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/28/2017 9:08 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.314113	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		18,757,727	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		53,617,536	6.00	
7.00	Medicaid cost (line 1 times line 6)		16,841,965	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)		0	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)		0	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)	3,665,442	0	3,665,442	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,151,363	0	1,151,363	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,151,363	0	1,151,363	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)		4,425,443		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		224,107		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		344,780		27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)		4,080,663		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,402,462		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,553,825		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,553,825		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet A	
Date/Time Prepared: 11/28/2017 9:08 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	NEW CAP REL COSTS-BLDG & FIXT		2,094,057	2,094,057	-39,207	2,054,850	1.00
1.01	00101	NEW CAP RELATED IRC		386,988	386,988	0	386,988	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,516,925	2,516,925	0	2,516,925	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,274	3,074,866	3,079,140	0	3,079,140	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,039,497	23,153,732	24,193,229	0	24,193,229	5.00
7.00	00700	OPERATION OF PLANT	518,281	2,617,752	3,136,033	0	3,136,033	7.00
7.01	00701	OPERATION OF PLANT IRC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	51,058	54,992	106,050	-32,421	73,629	8.00
9.00	00900	HOUSEKEEPING	0	775,340	775,340	-105,998	669,342	9.00
10.00	01000	DIETARY	0	675,095	675,095	-121,304	553,791	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	707,941	86,605	794,546	0	794,546	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	117,106	228,045	345,151	0	345,151	14.00
15.00	01500	PHARMACY	1,686,344	406,412	2,092,756	0	2,092,756	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,879,376	2,349,802	8,229,178	-366,560	7,862,618	30.00
31.00	03100	INTENSIVE CARE UNIT	909,462	291,352	1,200,814	0	1,200,814	31.00
43.00	04300	NURSERY	0	0	0	366,560	366,560	43.00
44.00	04400	SKILLED NURSING FACILITY	3,078,089	2,101,912	5,180,001	-24,581	5,155,420	44.00
45.00	04500	NURSING FACILITY	291,972	22,081	314,053	54,767	368,820	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,579,409	1,107,024	2,686,433	0	2,686,433	50.00
53.00	05300	ANESTHESIOLOGY	0	210,076	210,076	0	210,076	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,072,454	598,411	1,670,865	0	1,670,865	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	72,531	215,349	287,880	0	287,880	55.00
57.00	05700	CT SCAN	217,396	87,567	304,963	0	304,963	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99,972	17,908	117,880	0	117,880	58.00
59.00	05900	CARDIAC CATHETERIZATION	467,424	482,813	950,237	0	950,237	59.00
60.00	06000	LABORATORY	2,236,555	3,860,048	6,096,603	0	6,096,603	60.00
65.00	06500	RESPIRATORY THERAPY	1,041,511	331,178	1,372,689	0	1,372,689	65.00
66.00	06600	PHYSICAL THERAPY	1,923,058	444,333	2,367,391	0	2,367,391	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,144,284	4,144,284	-2,633,247	1,511,037	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,633,247	2,633,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,469,958	5,469,958	0	5,469,958	73.00
76.00	03020	CARDIAC REHAB	390,887	118,751	509,638	0	509,638	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	39,915	4,178	44,093	0	44,093	90.00
90.01	09001	WOUND CENTER	211,360	273,946	485,306	0	485,306	90.01
91.00	09100	EMERGENCY	2,331,053	3,878,878	6,209,931	0	6,209,931	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,068,857	1,198,405	4,267,262	70,789	4,338,051	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,035,782	63,279,063	92,314,845	-197,955	92,116,890	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	42,425	42,425	19,429	61,854	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	24,049	604,050	628,099	8,210	636,309	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	47,770	47,770	192.01
194.00	07950	CROSSTOWN SQUARE	133,892	867,529	1,001,421	1,242	1,002,663	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	117,216	117,216	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	4,088	4,088	194.03
194.04	07951	OUTREACH	0	1	1	0	1	194.04
200.00		TOTAL (SUM OF LINES 118-199)	29,193,723	64,793,068	93,986,791	0	93,986,791	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0275

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

Worksheet A
Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			
	00100			
1.00	00100			
1.01	00101			
2.00	00200			
2.00	00200			
2.01	00201			
2.01	00201			
3.00	00300			
3.00	00300			
4.00	00400			
4.00	00400			
5.00	00500			
5.00	00500			
7.00	00700			
7.00	00700			
7.01	00701			
7.01	00701			
8.00	00800			
8.00	00800			
9.00	00900			
9.00	00900			
10.00	01000			
10.00	01000			
11.00	01100			
11.00	01100			
13.00	01300			
13.00	01300			
14.00	01400			
14.00	01400			
15.00	01500			
15.00	01500			
16.00	01600			
16.00	01600			
17.00	01700			
17.00	01700			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000			
30.00	03000			
31.00	03100			
31.00	03100			
43.00	04300			
43.00	04300			
44.00	04400			
44.00	04400			
45.00	04500			
45.00	04500			
ANCILLARY SERVICE COST CENTERS				
50.00	05000			
50.00	05000			
53.00	05300			
53.00	05300			
54.00	05400			
54.00	05400			
55.00	05500			
55.00	05500			
57.00	05700			
57.00	05700			
58.00	05800			
58.00	05800			
59.00	05900			
59.00	05900			
60.00	06000			
60.00	06000			
65.00	06500			
65.00	06500			
66.00	06600			
66.00	06600			
71.00	07100			
71.00	07100			
72.00	07200			
72.00	07200			
73.00	07300			
73.00	07300			
76.00	03020			
76.00	03020			
OUTPATIENT SERVICE COST CENTERS				
90.00	09000			
90.00	09000			
90.01	09001			
90.01	09001			
91.00	09100			
91.00	09100			
92.00	09200			
92.00	09200			
OTHER REIMBURSABLE COST CENTERS				
95.00	09500			
95.00	09500			
SPECIAL PURPOSE COST CENTERS				
113.00	11300			
113.00	11300			
118.00				
118.00				
NONREIMBURSABLE COST CENTERS				
190.00	19000			
190.00	19000			
192.00	19200			
192.00	19200			
192.01	19201			
192.01	19201			
194.00	07950			
194.00	07950			
194.02	07952			
194.02	07952			
194.03	07953			
194.03	07953			
194.04	07951			
194.04	07951			
200.00				
200.00				

RECLASSIFICATIONS

Provider CCN: 14-0275

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

Worksheet A-6

Date/Time Prepared:
11/28/2017 9:08 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - POB DEPRECIATION					
1.00	NONREIMBURSABLE	192.01	0	39,207	1.00
	O		0	39,207	
B - NURSING HOME OVERHEAD COSTS					
1.00	NURSING FACILITY	45.00	19,371	33,343	1.00
	O		19,371	33,343	
C - NURSERY COSTS					
1.00	NURSERY	43.00	305,900	60,660	1.00
	O		305,900	60,660	
D - CHARGEABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO	72.00	0	2,633,247	1.00
	PATIENT				
	O		0	2,633,247	
E - DIETARY COST AND EMPLOYEE MEALS					
1.00	NONALLOWABLE PHYSICIAN	194.02	0	117,216	1.00
2.00	NONALLOWABLE GUEST MEALS	194.03	0	4,088	2.00
	O		0	121,304	
F - RECLASS HOUSEKEEPING COST					
1.00	AMBULANCE SERVICES	95.00	0	70,789	1.00
2.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	19,429	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,217	3.00
4.00	NONREIMBURSABLE	192.01	0	8,563	4.00
	O		0	105,998	
G - RECLASS LAUNDRY COST					
1.00	SKILLED NURSING FACILITY	44.00	13,545	14,588	1.00
2.00	NURSING FACILITY	45.00	988	1,065	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	478	515	3.00
4.00	CROSSTOWN SQUARE	194.00	598	644	4.00
	O		15,609	16,812	
500.00	Grand Total: Increases		340,880	3,010,571	500.00

RECLASSIFICATIONS

Provider CCN: 14-0275

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

Worksheet A-6

Date/Time Prepared:
11/28/2017 9:08 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - POB DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG & FI XT	1.00	0	39,207		9	1.00
			0	39,207			
B - NURSING HOME OVERHEAD COSTS							
1.00	SKILLED NURSING FACILITY	44.00	19,371	33,343		0	1.00
			19,371	33,343			
C - NURSERY COSTS							
1.00	ADULTS & PEDIATRICS	30.00	305,900	60,660		0	1.00
			305,900	60,660			
D - CHARGEABLE SUPPLIES							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,633,247		0	1.00
			0	2,633,247			
E - DIETARY COST AND EMPLOYEE MEALS							
1.00	DIETARY	10.00	0	117,216		0	1.00
2.00	DIETARY	10.00	0	4,088		0	2.00
			0	121,304			
F - RECLASS HOUSEKEEPING COST							
1.00	HOUSEKEEPING	9.00	0	105,998		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
			0	105,998			
G - RECLASS LAUNDRY COST							
1.00	LAUNDRY & LINEN SERVICE	8.00	15,609	16,812		0	1.00
2.00		0.00	0	0		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
			15,609	16,812			
500.00	Grand Total : Decreases		340,880	3,010,571			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

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

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2017 9:08 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,374,122	0	0	0	1.00
2.00	Land Improvements	5,010,215	33,320	0	33,320	2.00
3.00	Buildings and Fixtures	61,013,109	1,291,386	0	1,291,386	3.00
4.00	Building Improvements	2,090,594	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	48,456,255	1,639,997	0	1,639,997	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	118,944,295	2,964,703	0	2,964,703	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	118,944,295	2,964,703	0	2,964,703	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,374,122	0			1.00
2.00	Land Improvements	5,043,535	0			2.00
3.00	Buildings and Fixtures	62,304,495	0			3.00
4.00	Building Improvements	2,090,594	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	50,096,252	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	121,908,998	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	121,908,998	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

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

Worksheet A-7
Part II
Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	2,094,057	0	0	0	0	1.00
1.01	NEW CAP RELATED IRC	386,988	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,516,925	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	4,997,970	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2,094,057				1.00
1.01	NEW CAP RELATED IRC	0	386,988				1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,516,925				2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0				2.01
3.00	Total (sum of lines 1-2)	0	4,997,970				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0275

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

Worksheet A-7
Part III
Date/Time Prepared:
11/28/2017 9:08 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	NEW CAP REL COSTS-BLDG & FIXT	69,438,624	0	69,438,624	0.580907	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	50,096,252	0	50,096,252	0.419093	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	119,534,876	0	119,534,876	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,054,850	0	1.00
1.01	NEW CAP RELATED IRC	0	0	0	386,988	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,516,925	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,958,763	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-164,407	0	0	0	1,890,443	1.00
1.01	NEW CAP RELATED IRC	-102,441	0	0	0	284,547	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,516,925	2.00
2.01	CAP REL COSTS-MVBLE EQUIP IRC	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	-266,848	0	0	0	4,691,915	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:
11/28/2017 9:08 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
				Cost Center	Line #	
				3.00	4.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0 1.00
1.01	Investment income - NEW CAP RELATED IRC (chapter 2)			ONEW CAP RELATED IRC	1.01	0 1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
2.01	Investment income - CAP REL COSTS-MVBLE EQUIP IRC (chapter 2)			CAP REL COSTS-MVBLE EQUIP IRC	2.01	0 2.01
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	-4,552,298			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	-426,839			0 12.00
13.00	Laundry and linen service		0		0.00	0 13.00
14.00	Cafeteria-employees and guests		0		0.00	0 14.00
15.00	Rental of quarters to employee and others		0		0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00	Sale of drugs to other than patients		0		0.00	0 17.00
18.00	Sale of medical records and abstracts		0		0.00	0 18.00
19.00	Nursing 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		ORESPIRATORY THERAPY	65.00	23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY	66.00	24.00
25.00	Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00	25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			ONEW CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
26.01	Depreciation - NEW CAP RELATED IRC			ONEW CAP RELATED IRC	1.01	0 26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			ONEW CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
27.01	Depreciation - CAP REL COSTS-MVBLE EQUIP IRC			CAP REL COSTS-MVBLE EQUIP IRC	2.01	0 27.01
28.00	Non-physician Anesthetist			*** Cost Center Deleted ***	19.00	28.00
29.00	Physicians' assistant			0	0.00	0 29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0275

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
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
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 ADMINISTRATION - RENTAL INCOME -3RD	B	-37,496	ADMINISTRATIVE & GENERAL		5.00	0 33.00
34.00 PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-137,997	ADMINISTRATIVE & GENERAL		5.00	0 34.00
35.00 PHYSICIAN SUPPORT SVCS - RENTAL INCO	B	-1,320	ADMINISTRATIVE & GENERAL		5.00	0 35.00
35.03 ADMINISTRATION - DISCOUNTS EARNED	B	-6,549	ADMINISTRATIVE & GENERAL		5.00	0 35.03
35.05 ADMINISTRATION - MISCELLANEOUS REVEN	B	-10,607	ADMINISTRATIVE & GENERAL		5.00	0 35.05
35.07 SWITCHBOARD - MISCELLANEOUS REVENUE	B	-742	ADMINISTRATIVE & GENERAL		5.00	0 35.07
35.08 INFORMATION TECHNOLOGY - MISCELLANEO	B	-5,699	ADMINISTRATIVE & GENERAL		5.00	0 35.08
35.11 MEDICAL STAFF - ILLINI - MISCELLANEO	B	-33,900	ADMINISTRATIVE & GENERAL		5.00	0 35.11
35.13 ADMINISTRATION - CS - RENTAL INCOME -	B	-25,125	ADMINISTRATIVE & GENERAL		5.00	0 35.13
35.14 ADMINISTRATION - IRC - DISCOUNTS EARN	B	-29	ADMINISTRATIVE & GENERAL		5.00	0 35.14
36.03 SWITCHBOARD- CS - MISCELLANEOUS REVE	B	-8,217	ADMINISTRATIVE & GENERAL		5.00	0 36.03
36.07 SECURITY - INTERCOMPANY REVENUE	B	-25,600	OPERATION OF PLANT		7.00	0 36.07
36.08 GROUNDS - INTERCOMPANY REVENUE	B	-3,092	OPERATION OF PLANT		7.00	0 36.08
36.09 MAINTENANCE - MISCELLANEOUS REVENUE	B	-2,850	OPERATION OF PLANT		7.00	0 36.09
36.10 LAUNDRY - INTERCOMPANY REVENUE	B	-48,594	LAUNDRY & LINEN SERVICE		8.00	0 36.10
36.11 NUTRITIONAL SERVICES - VENDING SALES	B	-9,152	DIETARY		10.00	0 36.11
36.13 NUTRITIONAL SERVICES - MISCELLANEOUS	B	5,063	DIETARY		10.00	0 36.13
36.14 FOOD SERVICE - IRC - MISCELLANEOUS R	B	-4,396	DIETARY		10.00	0 36.14
36.15 FOOD SERVICE - CS - MISCELLANEOUS RE	B	-3,201	DIETARY		10.00	0 36.15
36.18 PHARMACY - INTERCOMPANY REVENUE	B	-23,781	PHARMACY		15.00	0 36.18
36.20 BIRTH ASSOCIATES - MISCELLANEOUS REV	B	-1,170	ADULTS & PEDIATRICS		30.00	0 36.20
36.21 PEDIATRICS - MISCELLANEOUS REVENUE	B	-80	ADULTS & PEDIATRICS		30.00	0 36.21
37.00 CCU - MISCELLANEOUS REVENUE	B	-210	INTENSIVE CARE UNIT		31.00	0 37.00
37.06 ACTIVITY - IRC - OUTREACH REVENUE	B	150	SKILLED NURSING FACILITY		44.00	0 37.06
37.07 NURSING FLOOR - IRC MEDICARE - MISCE	B	-2,416	SKILLED NURSING FACILITY		44.00	0 37.07
37.09 GIC-MLI-GENRADIL - OUTREACH REVENUE	B	-196,852	RADIOLOGY-DIAGNOSTIC		54.00	0 37.09
37.10 RADIOLOGY - INTERCOMPANY REVENUE	B	-4,809	RADIOLOGY-DIAGNOSTIC		54.00	0 37.10
37.11 LABORATORY - INTERCOMPANY REVENUE	B	-53,007	LABORATORY		60.00	0 37.11
37.12 LABORATORY - MISCELLANEOUS REVENUE	B	-260,663	LABORATORY		60.00	0 37.12
37.14 CARDIOPULMONARY SERVICES - CLINIC RE	B	25	RESPIRATORY THERAPY		65.00	0 37.14
38.00 P. T. CLINIC -MOLINE HEALTHPLEX - INT	B	-98,743	PHYSICAL THERAPY		66.00	0 38.00
39.00 PHYSICAL THERAPY - MISCELLANEOUS REV	B	-907	PHYSICAL THERAPY		66.00	0 39.00

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				1.00	2.00		
39.01	P. T. CLINIC -MOLINE HEALTHPLEX - MIS	B	-40	PHYSICAL THERAPY	66.00	0	39.01
39.02	PHYSICAL THERAPY - RENTAL INCOME - R	B	-55,644	PHYSICAL THERAPY	66.00	0	39.02
39.03	DISTRIBUTION - MISCELLANEOUS REVENUE	B	-940	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	39.03
39.04	CARDIAC REHAB - MISCELLANEOUS REVENUE	B	-780	CARDIAC REHAB	76.00	0	39.04
40.00	DIABETES CARE CENTER - MISCELLANEOUS	B	-140	CLINIC	90.00	0	40.00
41.00	WOUND CENTER - MISCELLANEOUS REVENUE	B	-20	WOUND CENTER	90.01	0	41.00
42.00	TRAUMA - MISCELLANEOUS REVENUE	B	-29,513	EMERGENCY	91.00	0	42.00
42.01	AMBULANCE - CPE REVENUE	B	-35,051	AMBULANCE SERVICES	95.00	0	42.01
43.00	AMBULANCE - MISCELLANEOUS REVENUE	B	-687,201	AMBULANCE SERVICES	95.00	0	43.00
43.02	AMBULANCE OUTREACH - MISCELLANEOUS R	B	-702,282	AMBULANCE SERVICES	95.00	0	43.02
43.03	AUXILIARY - GIFT SHOP - MISCELLANEOUS	B	-78,519	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.03
43.04	AUXILIARY - MISCELLANEOUS REVENUE	B	-27,847	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.04
43.06	BEAUTY SHOP - IRC - MISCELLANEOUS RE	B	-15,758	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.06
43.07	BEAUTY SHOP - CS - MISCELLANEOUS REV	B	-10,479	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	43.07
43.09	PHYSICIAN OFFICE - RENTAL INCOME -3R	B	-111,472	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.09
43.10	2526 41ST ST. - MOLINE - RENTAL INCO	B	-28,140	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.10
43.11	GENESIS HEALTHPLEX-MOLINE - RENTAL I	B	-98,655	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.11
43.12	PHYSICIAN OFFICE - RENTAL INCOME - R	B	-125,217	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.12
43.13	2526 41ST ST. - MOLINE - RENTAL INCO	B	-110,942	PHYSICIANS' PRIVATE OFFICES	192.00	0	43.13
43.14	ACTIVITY - CS - OUTREACH REVENUE	B	50	CROSSTOWN SQUARE	194.00	0	43.14
43.15	NURSING FLOOR - CS - MISCELLANEOUS R	B	-5	CROSSTOWN SQUARE	194.00	0	43.15
44.00	ENVIRONMENTAL SVC - OUTREACH - OTHER	B	-6,568	OUTREACH	194.04	0	44.00
44.01	INTEREST - INTEREST EXPENSE - 2010 B	B	-186,654	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	44.01
44.02	INTEREST - INTEREST EXP CAP INT OFF	A	22,247	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	44.02
44.03	INTEREST- IRC - INTEREST EXPENSE - R	A	-102,441	NEW CAP RELATED IRC	1.01	11	44.03
44.04	INTEREST - CS - INTEREST EXPENSE - R	A	-37,889	CROSSTOWN SQUARE	194.00	0	44.04
44.05	ADMINISTRATION - MISCELLANEOUS REVEN	A	-2	ADMINISTRATIVE & GENERAL	5.00	0	44.05
44.06	NURSING FLOOR - IRC MEDICARE - CONTR	A	-68,107	SKILLED NURSING FACILITY	44.00	0	44.06
45.00	ENVIRONMENTAL SVCS - IRC - CONTRACT	A	-47,506	SKILLED NURSING FACILITY	44.00	0	45.00
45.01	ENVIRONMENTAL SVC - CS - CONTRACT FE	A	-1,088	CROSSTOWN SQUARE	194.00	0	45.01
45.02	SECURITY - IRC - CONTRACT FEES- ILLI	A	-17,400	SKILLED NURSING FACILITY	44.00	0	45.02
45.03	SECURITY - CS - CONTRACT FEES- ILLIN	A	-8,200	CROSSTOWN SQUARE	194.00	0	45.03
45.04	ADMINISTRATION - PHYSICIAN PRACTICE	A	-3,573,496	ADMINISTRATIVE & GENERAL	5.00	0	45.04
45.05	PHYSICIAN SUPPORT SVCS	A	-159,826	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	MEDICAL STAFF - ILLINI - DONATIONS	A	-12,050	ADMINISTRATIVE & GENERAL	5.00	0	45.06
45.07			0		0.00	0	45.07
45.08	ADVERTISING & PROMOTIONS	A	-20,236	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09	ADVERTISING & PROMOTIONS	A	-129	NURSING ADMINISTRATION	13.00	0	45.09
45.10	ADVERTISING & PROMOTIONS	A	-18	SKILLED NURSING FACILITY	44.00	0	45.10

Provider CCN: 14-0275 Period: From 07/01/2016 To 06/30/2017 Worksheet A-8
 Date/Time Prepared: 11/28/2017 9:08 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
45.11 ADVERTISING & PROMOTIONS	A	-149	RADIOLOGY-DIAGNOSTIC	54.00	0 45.11
45.12		0		0.00	0 45.12
45.13 ADVERTISING & PROMOTIONS	A	-11,973	PHYSICAL THERAPY	66.00	0 45.13
45.14		0		0.00	0 45.14
45.15 ADVERTISING & PROMOTIONS	A	-194	CROSTOWN SQUARE	194.00	0 45.15
45.16 ADMINISTRATION - PROVIDER TAX ASSESS	A	-2,985,197	ADMINISTRATIVE & GENERAL	5.00	0 45.16
45.17 NURSING ADMIN - IRC - PROVIDER TAX A	A	-50,370	SKILLED NURSING FACILITY	44.00	0 45.17
45.18 ADMINISTRATOR - IRC - PROVIDER TAX A	A	-142,850	ADMINISTRATIVE & GENERAL	5.00	0 45.18
45.19 SELF INSURANCE	A	-910,362	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.19
45.20		0		0.00	0 45.20
45.21		0		0.00	0 45.21
45.22		0		0.00	0 45.22
45.23		0		0.00	0 45.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,420,156			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: 14-0275
 Period: From 07/01/2016 To 06/30/2017
 Worksheet A-8-1
 Date/Time Prepared: 11/28/2017 9:08 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	GHS HOME OFFICE COSTS	11,794,517	13,729,831 1.00
2.00	0.00			0	0 2.00
3.00	0.00			0	0 3.00
4.00	14.00	CENTRAL SERVICES & SUPPLY	GHS HOME OFFICE COSTS	384,487	0 4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	GHS HOME OFFICE COSTS	1,123,988	0 4.01
4.02	0.00			0	0 4.02
4.03	0.00			0	0 4.03
4.04	0.00		GHS HOME OFFICE COSTS	0	0 4.04
5.00	0			13,302,992	13,729,831 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	C		0.00	GENESIS HEALTH SYSTEM	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0275

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2017 9:08 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	-1,935,314	0		1.00
2.00	0	9		2.00
3.00	0	0		3.00
4.00	384,487	0		4.00
4.01	1,123,988	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
5.00	-426,839			5.00

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

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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0275

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2017 9:08 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	292,098	0	292,098	211,500	2,873	1.00
2.00	30.00	ADULTS & PEDIATRICS	956,951	956,951	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	11,538	11,538	0	0	0	3.00
4.00	50.00	OPERATING ROOM	11,500	11,500	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	180,000	180,000	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	59,604	58,025	1,579	211,500	16	7.00
8.00	90.01	WOUND CENTER	37,500	37,500	0	0	0	8.00
9.00	91.00	EMERGENCY	3,309,084	3,296,784	12,300	211,500	121	9.00
10.00	95.00	AMBULANCE SERVICES	12,578	0	12,578	211,500	124	10.00
200.00			4,870,853	4,552,298	318,555		3,134	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	292,134	14,607	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	1,627	81	0	0	0	7.00
8.00	90.01	WOUND CENTER	0	0	0	0	0	8.00
9.00	91.00	EMERGENCY	12,304	615	0	0	0	9.00
10.00	95.00	AMBULANCE SERVICES	12,609	630	0	0	0	10.00
200.00			318,674	15,933	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	292,134	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	956,951	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	11,538	3.00
4.00	50.00	OPERATING ROOM	0	0	0	11,500	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	180,000	5.00
6.00	60.00	LABORATORY	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	0	1,627	0	58,025	7.00
8.00	90.01	WOUND CENTER	0	0	0	37,500	8.00
9.00	91.00	EMERGENCY	0	12,304	0	3,296,784	9.00
10.00	95.00	AMBULANCE SERVICES	0	12,609	0	0	10.00
200.00			0	318,674	0	4,552,298	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

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

Worksheet B
Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP	MVBLE EQUIP IRC	
		1.00	1.01	2.00	2.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,890,443	1,890,443			1.00
1.01 00101	NEW CAP RELATED IRC	284,547	0	284,547		1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	2,516,925			2,516,925	2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP IRC	0			0	2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,168,778	4,599	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,096,577	441,383	0	270,822	5.00
7.00 00700	OPERATION OF PLANT	3,104,491	178,434	0	113,850	7.00
7.01 00701	OPERATION OF PLANT IRC	0	0	12,175	0	7.01
8.00 00800	LAUNDRY & LINEN SERVICE	25,035	19,659	983	0	8.00
9.00 00900	HOUSEKEEPING	669,342	8,967	2,150	5,702	9.00
10.00 01000	DIETARY	542,105	43,366	0	33,434	10.00
11.00 01100	CAFETERIA	0	24,077	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	794,417	6,405	0	4,995	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	729,638	54,920	0	32,472	14.00
15.00 01500	PHARMACY	2,068,975	38,103	0	105,500	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,123,988	22,599	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	9,066	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,904,417	353,222	0	240,531	30.00
31.00 03100	INTENSIVE CARE UNIT	1,189,066	30,712	0	56,126	31.00
43.00 04300	NURSERY	366,560	17,811	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	4,969,753	0	162,460	13,185	44.00
45.00 04500	NURSING FACILITY	368,820	0	78,269	274	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,674,933	132,267	0	278,935	50.00
53.00 05300	ANESTHESIOLOGY	30,076	0	0	57,728	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,469,055	72,740	0	253,703	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	287,880	0	0	0	55.00
57.00 05700	CT SCAN	304,963	0	0	241,406	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	117,880	1,495	0	6,091	58.00
59.00 05900	CARDIAC CATHETERIZATION	950,237	19,774	0	113,900	59.00
60.00 06000	LABORATORY	5,782,933	123,045	0	118,034	60.00
65.00 06500	RESPIRATORY THERAPY	1,314,689	23,092	0	71,190	65.00
66.00 06600	PHYSICAL THERAPY	2,200,084	27,805	21,925	24,864	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,510,097	0	0	67,755	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	2,633,247	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,469,958	0	0	0	73.00
76.00 03020	CARDIAC REHAB	508,858	71,443	0	7,063	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	43,953	0	0	0	90.00
90.01 09001	WOUND CENTER	447,786	15,545	0	5,213	90.01
91.00 09100	EMERGENCY	2,883,634	72,559	0	73,261	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	2,913,517	58,312	0	316,625	95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	76,357,657	1,871,400	277,962	2,512,659	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-70,749	13,098	1,922	593	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	161,883	5,945	0	2,075	192.00
192.01 19201	NONREIMBURSABLE	47,770	0	4,663	43	192.01
194.00 07950	CROSSTOWN SQUARE	955,337	0	0	1,555	194.00
194.02 07952	NONALLOWABLE PHYSICIAN	117,216	0	0	0	194.02
194.03 07953	NONALLOWABLE GUEST MEALS	4,088	0	0	0	194.03
194.04 07951	OUTREACH	-6,567	0	0	0	194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	77,566,635	1,890,443	284,547	2,516,925	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
		4.00	4A	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,173,377				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	71,833	15,880,615	15,880,615		5.00
7.00	00700	OPERATION OF PLANT	38,692	3,435,467	883,551	4,319,018	7.00
7.01	00701	OPERATION OF PLANT IRC	0	12,175	3,131	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	2,646	48,323	12,428	67,066	55 8.00
9.00	00900	HOUSEKEEPING	0	686,161	176,470	30,592	121 9.00
10.00	01000	DIETARY	0	618,905	159,173	147,943	0 10.00
11.00	01100	CAFETERIA	0	24,077	6,192	82,138	0 11.00
13.00	01300	NURSING ADMINISTRATION	52,851	858,668	220,837	21,851	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,743	825,773	212,376	187,360	0 14.00
15.00	01500	PHARMACY	125,894	2,338,472	601,420	129,986	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,146,587	294,885	77,095	0 16.00
17.00	01700	SOCIAL SERVICE	0	9,066	2,332	30,928	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	416,096	7,914,266	2,035,459	1,205,008	0 30.00
31.00	03100	INTENSIVE CARE UNIT	67,896	1,343,800	345,605	104,773	0 31.00
43.00	04300	NURSERY	22,837	407,208	104,728	60,763	0 43.00
44.00	04400	SKILLED NURSING FACILITY	229,360	5,374,758	1,382,307	0	9,130 44.00
45.00	04500	NURSING FACILITY	23,317	470,680	121,052	0	4,398 45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	117,911	3,204,046	824,033	451,226	0 50.00
53.00	05300	ANESTHESIOLOGY	0	87,804	22,582	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80,064	1,875,562	482,366	248,151	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,415	293,295	75,431	0	0 55.00
57.00	05700	CT SCAN	16,230	562,599	144,692	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,463	132,929	34,187	5,099	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	34,896	1,118,807	287,740	67,458	0 59.00
60.00	06000	LABORATORY	166,970	6,190,982	1,592,228	419,766	0 60.00
65.00	06500	RESPIRATORY THERAPY	77,754	1,486,725	382,363	78,776	0 65.00
66.00	06600	PHYSICAL THERAPY	143,566	2,418,244	621,936	94,856	1,232 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,577,852	405,800	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,633,247	677,232	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,469,958	1,406,791	0	0 73.00
76.00	03020	CARDIAC REHAB	29,182	616,546	158,566	243,724	0 76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	2,980	46,933	12,070	0	0 90.00
90.01	09001	WOUND CENTER	15,779	484,323	124,561	53,031	0 90.01
91.00	09100	EMERGENCY	174,025	3,203,479	823,887	247,534	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	229,106	3,517,560	904,664	198,929	0 95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,161,506	76,315,892	15,543,075	4,254,053	14,936 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-55,136	0	44,683	108 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,831	171,734	44,167	20,282	0 192.00
192.01	19201	NONREIMBURSABLE	0	52,476	13,496	0	262 192.01
194.00	07950	CROSSTOWN SQUARE	10,040	966,932	248,680	0	0 194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	117,216	30,146	0	0 194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	4,088	1,051	0	0 194.03
194.04	07951	OUTREACH	0	-6,567	0	0	0 194.04
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118-201)	2,173,377	77,566,635	15,880,615	4,319,018	15,306 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 11/28/2017 9:08 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	127,872				8.00
9.00	00900	HOUSEKEEPING	0	893,344			9.00
10.00	01000	DIETARY	0	33,562	959,583		10.00
11.00	01100	CAFETERIA	0	18,633	747,721	878,761	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,957	0	16,730	1,123,043
14.00	01400	CENTRAL SERVICES & SUPPLY	463	42,504	0	7,108	0
15.00	01500	PHARMACY	0	10,060	0	32,788	6,379
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,490	0	0	0
17.00	01700	SOCIAL SERVICE	0	7,016	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,801	273,363	192,201	173,667	625,297
31.00	03100	INTENSIVE CARE UNIT	3,568	23,768	19,661	22,909	84,595
43.00	04300	NURSERY	2,059	13,784	0	0	0
44.00	04400	SKILLED NURSING FACILITY	38,978	0	0	126,162	0
45.00	04500	NURSING FACILITY	2,756	0	0	14,802	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,735	102,363	0	43,528	141,744
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,431	56,294	0	33,442	156
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	1,756	0
57.00	05700	CT SCAN	3,670	0	0	6,265	18
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	585	1,157	0	2,461	9
59.00	05900	CARDIAC CATHETERIZATION	1,534	15,303	0	7,143	14,373
60.00	06000	LABORATORY	15	56,244	0	80,706	498
65.00	06500	RESPIRATORY THERAPY	1,332	17,871	0	32,771	34
66.00	06600	PHYSICAL THERAPY	1,250	25,669	0	52,788	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CARDIAC REHAB	46	37,547	0	10,654	16,122
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	1,480	1,639
90.01	09001	WOUND CENTER	0	12,030	0	6,523	20,581
91.00	09100	EMERGENCY	18,268	56,155	0	58,606	211,305
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	45,128	0	137,608	220
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	126,491	870,898	959,583	869,897	1,122,970
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,386	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,381	4,601	0	1,291	0
192.01	19201	NONREIMBURSABLE	0	5,459	0	0	0
194.00	07950	CROSSTOWN SQUARE	0	0	0	7,573	73
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0
194.04	07951	OUTREACH	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	127,872	893,344	959,583	878,761	1,123,043

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0275

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

Worksheet B Part I Date/Time Prepared: 11/28/2017 9:08 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		14.00	15.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
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	1,275,584				14.00
15.00	01500	PHARMACY	11,320	3,130,425			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,536,057		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	49,342	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,273	0	119,191	29,660	12,678,186
31.00	03100	INTENSIVE CARE UNIT	17,972	0	25,525	1,084	1,993,260
43.00	04300	NURSERY	0	0	6,044	3,088	597,674
44.00	04400	SKILLED NURSING FACILITY	41,344	0	56,042	0	7,028,721
45.00	04500	NURSING FACILITY	0	0	7,097	0	620,785
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	127,753	0	118,157	15,510	5,047,095
53.00	05300	ANESTHESIOLOGY	5,696	0	21,002	0	137,084
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,073	0	77,875	0	2,786,350
55.00	05500	RADIOLOGY-THERAPEUTIC	38,769	0	18,621	0	427,872
57.00	05700	CT SCAN	11,855	0	125,622	0	854,721
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	560	0	26,151	0	203,138
59.00	05900	CARDIAC CATHETERIZATION	19,047	0	68,914	0	1,600,319
60.00	06000	LABORATORY	10,606	0	248,329	0	8,599,374
65.00	06500	RESPIRATORY THERAPY	21,172	0	97,355	0	2,118,399
66.00	06600	PHYSICAL THERAPY	2,648	0	59,669	0	3,278,292
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,528	0	39,872	0	2,316,052
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	504,193	0	73,175	0	3,887,847
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,130,425	147,623	0	10,154,797
76.00	03020	CARDIAC REHAB	1,723	0	6,480	0	1,091,408
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	36	0	1,038	0	63,196
90.01	09001	WOUND CENTER	9,905	0	27,914	0	738,868
91.00	09100	EMERGENCY	53,189	0	164,361	0	4,836,784
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	15,896	0	0	0	4,820,005
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,275,558	3,130,425	1,536,057	49,342	75,880,227
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	2,041
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	243,456
192.01	19201	NONREIMBURSABLE	0	0	0	0	71,693
194.00	07950	CROSSTOWN SQUARE	22	0	0	0	1,223,280
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	147,362
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	5,139
194.04	07951	OUTREACH	4	0	0	0	-6,563
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers					0
202.00		TOTAL (sum lines 118-201)	1,275,584	3,130,425	1,536,057	49,342	77,566,635

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 11/28/2017 9:08 am
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
		25.00	26.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	NEW CAP RELATED IRC			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC			2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT IRC			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	12,678,186	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,993,260	31.00
43.00	04300	NURSERY	0	597,674	43.00
44.00	04400	SKILLED NURSING FACILITY	0	7,028,721	44.00
45.00	04500	NURSING FACILITY	0	620,785	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,047,095	50.00
53.00	05300	ANESTHESIOLOGY	0	137,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,786,350	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	427,872	55.00
57.00	05700	CT SCAN	0	854,721	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	203,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,600,319	59.00
60.00	06000	LABORATORY	0	8,599,374	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,118,399	65.00
66.00	06600	PHYSICAL THERAPY	0	3,278,292	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,316,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,887,847	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,154,797	73.00
76.00	03020	CARDIAC REHAB	0	1,091,408	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	63,196	90.00
90.01	09001	WOUND CENTER	0	738,868	90.01
91.00	09100	EMERGENCY	0	4,836,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	4,820,005	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	75,880,227	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,041	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	243,456	192.00
192.01	19201	NONREIMBURSABLE	0	71,693	192.01
194.00	07950	CROSSTOWN SQUARE	0	1,223,280	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	147,362	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	5,139	194.03
194.04	07951	OUTREACH	0	-6,563	194.04
200.00		Cross Foot Adjustments	0	0	200.00
201.00		Negative Cost Centers	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	77,566,635	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0275

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS					
		Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW CAP RELATED IRC	NEW MVBLE EQUIP		MVBLE EQUIP IRC
			0	1.00	1.01		2.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00	
1.01	00101	NEW CAP RELATED IRC				1.01	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00	
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC				2.01	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,599	0	0	
5.00	00500	ADMINISTRATIVE & GENERAL	342,632	441,383	0	270,822	
7.00	00700	OPERATION OF PLANT	459,019	178,434	0	113,850	
7.01	00701	OPERATION OF PLANT IRC	0	0	12,175	0	
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,659	983	0	
9.00	00900	HOUSEKEEPING	9,111	8,967	2,150	5,702	
10.00	01000	DIETARY	36,611	43,366	0	33,434	
11.00	01100	CAFETERIA	0	24,077	0	0	
13.00	01300	NURSING ADMINISTRATION	4,030	6,405	0	4,995	
14.00	01400	CENTRAL SERVICES & SUPPLY	90,236	54,920	0	32,472	
15.00	01500	PHARMACY	110,234	38,103	0	105,500	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,599	0	0	
17.00	01700	SOCIAL SERVICE	0	9,066	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	100,945	353,222	0	240,531	
31.00	03100	INTENSIVE CARE UNIT	16,184	30,712	0	56,126	
43.00	04300	NURSERY	0	17,811	0	0	
44.00	04400	SKILLED NURSING FACILITY	99,218	0	162,460	13,185	
45.00	04500	NURSING FACILITY	0	0	78,269	274	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	83,628	132,267	0	278,935	
53.00	05300	ANESTHESIOLOGY	0	0	0	57,728	
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,433	72,740	0	253,703	
55.00	05500	RADIOLOGY-THERAPEUTIC	281	0	0	0	
57.00	05700	CT SCAN	220	0	0	241,406	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,731	1,495	0	6,091	
59.00	05900	CARDIAC CATHETERIZATION	5,139	19,774	0	113,900	
60.00	06000	LABORATORY	204,498	123,045	0	118,034	
65.00	06500	RESPIRATORY THERAPY	55,343	23,092	0	71,190	
66.00	06600	PHYSICAL THERAPY	189,716	27,805	21,925	24,864	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	67,755	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	
76.00	03020	CARDIAC REHAB	73,174	71,443	0	7,063	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,091	0	0	0	
90.01	09001	WOUND CENTER	48,078	15,545	0	5,213	
91.00	09100	EMERGENCY	31,687	72,559	0	73,261	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	335,265	58,312	0	316,625	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,314,504	1,871,400	277,962	2,512,659	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,098	1,922	593	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	349,052	5,945	0	2,075	
192.01	19201	NONREIMBURSABLE	0	0	4,663	43	
194.00	07950	CROSSTOWN SQUARE	22,704	0	0	1,555	
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	
194.04	07951	OUTREACH	0	0	0	0	
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		TOTAL (sum lines 118-201)	2,686,260	1,890,443	284,547	2,516,925	

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/28/2017 9:08 am	
Cost Center Description			Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT IRC	
			2A	4.00	5.00	7.00	7.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP RELATED IRC						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,599	4,599				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,054,837	152	1,054,989			5.00
7.00	00700	OPERATION OF PLANT	751,303	82	58,695	810,080		7.00
7.01	00701	OPERATION OF PLANT IRC	12,175	0	208	0	12,383	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	20,642	6	826	12,579	45	8.00
9.00	00900	HOUSEKEEPING	25,930	0	11,723	5,738	98	9.00
10.00	01000	DIETARY	113,411	0	10,574	27,748	0	10.00
11.00	01100	CAFETERIA	24,077	0	411	15,406	0	11.00
13.00	01300	NURSING ADMINISTRATION	15,430	112	14,670	4,098	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	177,628	19	14,108	35,141	0	14.00
15.00	01500	PHARMACY	253,837	266	39,953	24,380	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,599	0	19,589	14,460	0	16.00
17.00	01700	SOCIAL SERVICE	9,066	0	155	5,801	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	694,698	881	135,242	226,015	0	30.00
31.00	03100	INTENSIVE CARE UNIT	103,022	144	22,959	19,651	0	31.00
43.00	04300	NURSERY	17,811	48	6,957	11,397	0	43.00
44.00	04400	SKILLED NURSING FACILITY	274,863	485	91,828	0	7,386	44.00
45.00	04500	NURSING FACILITY	78,543	49	8,042	0	3,558	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	494,830	250	54,741	84,632	0	50.00
53.00	05300	ANESTHESIOLOGY	57,728	0	1,500	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	339,876	169	32,044	46,543	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	281	11	5,011	0	0	55.00
57.00	05700	CT SCAN	241,626	34	9,612	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	12,317	16	2,271	956	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	138,813	74	19,115	12,653	0	59.00
60.00	06000	LABORATORY	445,577	353	105,773	78,732	0	60.00
65.00	06500	RESPIRATORY THERAPY	149,625	165	25,401	14,775	0	65.00
66.00	06600	PHYSICAL THERAPY	264,310	304	41,316	17,791	997	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	67,755	0	26,958	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	44,989	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	93,454	0	0	73.00
76.00	03020	CARDIAC REHAB	151,680	62	10,534	45,713	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,091	6	802	0	0	90.00
90.01	09001	WOUND CENTER	68,836	33	8,275	9,947	0	90.01
91.00	09100	EMERGENCY	177,507	368	54,731	46,428	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	710,202	485	60,098	37,311	0	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,976,525	4,574	1,032,565	797,895	12,084	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,613	0	0	8,381	87	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	357,072	4	2,934	3,804	0	192.00
192.01	19201	NONREIMBURSABLE	4,706	0	897	0	212	192.01
194.00	07950	CROSSTOWN SQUARE	24,259	21	16,520	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	2,003	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	70	0	0	194.03
194.04	07951	OUTREACH	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0					201.00
202.00		TOTAL (sum lines 118-201)	7,378,175	4,599	1,054,989	810,080	12,383	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 9:08 am
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Cost Center Description		LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	34,098				8.00
9.00	00900	HOUSEKEEPING	0	43,489			9.00
10.00	01000	DIETARY	0	1,634	153,367		10.00
11.00	01100	CAFETERIA	0	907	119,506	160,307	11.00
13.00	01300	NURSING ADMINISTRATION	0	241	0	3,052	37,603
14.00	01400	CENTRAL SERVICES & SUPPLY	124	2,069	0	1,297	0
15.00	01500	PHARMACY	0	490	0	5,981	214
16.00	01600	MEDICAL RECORDS & LIBRARY	0	851	0	0	0
17.00	01700	SOCIAL SERVICE	0	342	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,880	13,307	30,719	31,680	20,938
31.00	03100	INTENSIVE CARE UNIT	951	1,157	3,142	4,179	2,832
43.00	04300	NURSERY	549	671	0	0	0
44.00	04400	SKILLED NURSING FACILITY	10,394	0	0	23,015	0
45.00	04500	NURSING FACILITY	735	0	0	2,700	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,996	4,983	0	7,941	4,746
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,982	2,740	0	6,101	5
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	320	0
57.00	05700	CT SCAN	979	0	0	1,143	1
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	156	56	0	449	0
59.00	05900	CARDIAC CATHETERIZATION	409	745	0	1,303	481
60.00	06000	LABORATORY	4	2,738	0	14,723	17
65.00	06500	RESPIRATORY THERAPY	355	870	0	5,978	1
66.00	06600	PHYSICAL THERAPY	333	1,250	0	9,630	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
76.00	03020	CARDIAC REHAB	12	1,828	0	1,944	540
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	270	55
90.01	09001	WOUND CENTER	0	586	0	1,190	689
91.00	09100	EMERGENCY	4,871	2,734	0	10,691	7,075
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,197	0	25,103	7
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,730	42,396	153,367	158,690	37,601
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	603	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	368	224	0	235	0
192.01	19201	NONREIMBURSABLE	0	266	0	0	0
194.00	07950	CROSSTOWN SQUARE	0	0	0	1,382	2
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0
194.04	07951	OUTREACH	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	34,098	43,489	153,367	160,307	37,603

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 9:08 am		
Cost Center Description			CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal
			14.00	15.00	16.00	17.00	24.00
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP RELATED IRC					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT IRC					7.01
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	230,386				14.00
15.00	01500	PHARMACY	2,044	327,165			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	57,499		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	15,364	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,221	0	4,459	9,236	30.00
31.00	03100	INTENSIVE CARE UNIT	3,246	0	955	337	31.00
43.00	04300	NURSERY	0	0	226	962	43.00
44.00	04400	SKILLED NURSING FACILITY	7,467	0	2,097	0	44.00
45.00	04500	NURSING FACILITY	0	0	265	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,074	0	4,420	4,829	50.00
53.00	05300	ANESTHESIOLOGY	1,029	0	786	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	916	0	2,913	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	7,002	0	697	0	55.00
57.00	05700	CT SCAN	2,141	0	4,700	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	101	0	978	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,440	0	2,578	0	59.00
60.00	06000	LABORATORY	1,916	0	9,324	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,824	0	3,642	0	65.00
66.00	06600	PHYSICAL THERAPY	478	0	2,232	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,834	0	1,492	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	91,064	0	2,738	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	327,165	5,523	0	73.00
76.00	03020	CARDIAC REHAB	311	0	242	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6	0	39	0	90.00
90.01	09001	WOUND CENTER	1,789	0	1,044	0	90.01
91.00	09100	EMERGENCY	9,607	0	6,149	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,871	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	230,381	327,165	57,499	15,364	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	NONREIMBURSABLE	0	0	0	0	192.01
194.00	07950	CROSSTOWN SQUARE	4	0	0	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	0	0	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	0	0	0	194.03
194.04	07951	OUTREACH	1	0	0	0	194.04
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)	230,386	327,165	57,499	15,364	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 9:08 am
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP RELATED IRC		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP IRC		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT IRC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	CARDIAC REHAB	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CENTER	0	90.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	95.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	NONREIMBURSABLE	0	192.01
194.00	07950	CROSSTOWN SQUARE	0	194.00
194.02	07952	NONALLOWABLE PHYSICIAN	0	194.02
194.03	07953	NONALLOWABLE GUEST MEALS	0	194.03
194.04	07951	OUTREACH	0	194.04
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description	CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW CAP RELATED IRC (SQUARE FEET IRC)	NEW MVBLE EQUIP (DOLLAR VALUE)	MVBLE EQUIP IRC (DOLLAR VALUE)		
	1.00	1.01	2.00	2.01		
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	230,211				1.00
1.01 00101	NEW CAP RELATED IRC	0	52,420			1.01
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP			2,455,462		2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP IRC			0	0	2.01
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	560	0	0	0	29,112,152 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	53,750	0	264,209	0	962,200 5.00
7.00 00700	OPERATION OF PLANT	21,729	0	111,070	0	518,281 7.00
7.01 00701	OPERATION OF PLANT IRC	0	2,243	0	0	0 7.01
8.00 00800	LAUNDRY & LINEN SERVICE	2,394	181	0	0	35,449 8.00
9.00 00900	HOUSEKEEPING	1,092	396	5,563	0	0 9.00
10.00 01000	DIETARY	5,281	0	32,618	0	0 10.00
11.00 01100	CAFETERIA	2,932	0	0	0	0 11.00
13.00 01300	NURSING ADMINISTRATION	780	0	4,873	0	707,941 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,688	0	31,679	0	117,106 14.00
15.00 01500	PHARMACY	4,640	0	102,924	0	1,686,344 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,752	0	0	0	0 16.00
17.00 01700	SOCIAL SERVICE	1,104	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	43,014	0	234,657	0	5,573,476 30.00
31.00 03100	INTENSIVE CARE UNIT	3,740	0	54,755	0	909,462 31.00
43.00 04300	NURSERY	2,169	0	0	0	305,900 43.00
44.00 04400	SKILLED NURSING FACILITY	0	29,929	12,863	0	3,072,262 44.00
45.00 04500	NURSING FACILITY	0	14,419	267	0	312,332 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	16,107	0	272,123	0	1,579,409 50.00
53.00 05300	ANESTHESIOLOGY	0	0	56,318	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,858	0	247,508	0	1,072,454 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	72,531 55.00
57.00 05700	CT SCAN	0	0	235,511	0	217,396 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	182	0	5,942	0	99,972 58.00
59.00 05900	CARDIAC CATHETERIZATION	2,408	0	111,119	0	467,424 59.00
60.00 06000	LABORATORY	14,984	0	115,152	0	2,236,555 60.00
65.00 06500	RESPIRATORY THERAPY	2,812	0	69,452	0	1,041,511 65.00
66.00 06600	PHYSICAL THERAPY	3,386	4,039	24,257	0	1,923,058 66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	66,100	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
76.00 03020	CARDIAC REHAB	8,700	0	6,891	0	390,887 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	39,915 90.00
90.01 09001	WOUND CENTER	1,893	0	5,086	0	211,360 90.01
91.00 09100	EMERGENCY	8,836	0	71,472	0	2,331,053 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	7,101	0	308,891	0	3,068,857 95.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	227,892	51,207	2,451,300	0	28,953,135 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,595	354	579	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	724	0	2,024	0	24,527 192.00
192.01 19201	NONREIMBURSABLE	0	859	42	0	0 192.01
194.00 07950	CROSSTOWN SQUARE	0	0	1,517	0	134,490 194.00
194.02 07952	NONALLOWABLE PHYSICIAN	0	0	0	0	0 194.02
194.03 07953	NONALLOWABLE GUEST MEALS	0	0	0	0	0 194.03
194.04 07951	OUTREACH	0	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,890,443	284,547	2,516,925	0	2,173,377 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.211784	5.428214	1.025031	0.000000	0.074655 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)					4,599 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000158 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description		Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT IRC (SQUARE FEET IRC)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5A	5.00	7.00	7.01	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500	-15,880,615	61,747,723				5.00
7.00	00700	0	3,435,467	154,172			7.00
7.01	00701	0	12,175	0	50,177		7.01
8.00	00800	0	48,323	2,394	181	610,080	8.00
9.00	00900	0	686,161	1,092	396	0	9.00
10.00	01000	0	618,905	5,281	0	0	10.00
11.00	01100	0	24,077	2,932	0	0	11.00
13.00	01300	0	858,668	780	0	0	13.00
14.00	01400	0	825,773	6,688	0	2,210	14.00
15.00	01500	0	2,338,472	4,640	0	0	15.00
16.00	01600	0	1,146,587	2,752	0	0	16.00
17.00	01700	0	9,066	1,104	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	7,914,266	43,014	0	123,095	30.00
31.00	03100	0	1,343,800	3,740	0	17,022	31.00
43.00	04300	0	407,208	2,169	0	9,823	43.00
44.00	04400	0	5,374,758	0	29,929	185,965	44.00
45.00	04500	0	470,680	0	14,419	13,147	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	3,204,046	16,107	0	89,383	50.00
53.00	05300	0	87,804	0	0	0	53.00
54.00	05400	0	1,875,562	8,858	0	35,455	54.00
55.00	05500	0	293,295	0	0	0	55.00
57.00	05700	0	562,599	0	0	17,511	57.00
58.00	05800	0	132,929	182	0	2,793	58.00
59.00	05900	0	1,118,807	2,408	0	7,320	59.00
60.00	06000	0	6,190,982	14,984	0	71	60.00
65.00	06500	0	1,486,725	2,812	0	6,354	65.00
66.00	06600	0	2,418,244	3,386	4,039	5,965	66.00
71.00	07100	0	1,577,852	0	0	0	71.00
72.00	07200	0	2,633,247	0	0	0	72.00
73.00	07300	0	5,469,958	0	0	0	73.00
76.00	03020	0	616,546	8,700	0	221	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	46,933	0	0	0	90.00
90.01	09001	0	484,323	1,893	0	0	90.01
91.00	09100	0	3,203,479	8,836	0	87,158	91.00
92.00	09200	0					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	0	3,517,560	7,101	0	0	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0					113.00
118.00		-15,880,615	60,435,277	151,853	48,964	603,493	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	55,136	0	1,595	354	0	190.00
192.00	19200	0	171,734	724	0	6,587	192.00
192.01	19201	0	52,476	0	859	0	192.01
194.00	07950	0	966,932	0	0	0	194.00
194.02	07952	0	117,216	0	0	0	194.02
194.03	07953	0	4,088	0	0	0	194.03
194.04	07951	6,567	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00			15,880,615	4,319,018	15,306	127,872	202.00
203.00			0.257185	28.014283	0.305040	0.209599	203.00
204.00			1,054,989	810,080	12,383	34,098	204.00
205.00			0.017085	5.254391	0.246786	0.055891	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1

Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description		HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
2.00	00200						2.00
2.01	00201						2.01
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
7.01	00701						7.01
8.00	00800						8.00
9.00	00900	140,569					9.00
10.00	01000	5,281	146,223				10.00
11.00	01100	2,932	113,939	51,056			11.00
13.00	01300	780	0	972	367,241		13.00
14.00	01400	6,688	0	413	0	6,661,983	14.00
15.00	01500	1,583	0	1,905	2,086	59,119	15.00
16.00	01600	2,752	0	0	0	0	16.00
17.00	01700	1,104	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	43,014	29,288	10,090	204,475	440,130	30.00
31.00	03100	3,740	2,996	1,331	27,663	93,862	31.00
43.00	04300	2,169	0	0	0	0	43.00
44.00	04400	0	0	7,330	0	215,925	44.00
45.00	04500	0	0	860	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,107	0	2,529	46,351	667,214	50.00
53.00	05300	0	0	0	0	29,746	53.00
54.00	05400	8,858	0	1,943	51	26,497	54.00
55.00	05500	0	0	102	0	202,477	55.00
57.00	05700	0	0	364	6	61,915	57.00
58.00	05800	182	0	143	3	2,926	58.00
59.00	05900	2,408	0	415	4,700	99,477	59.00
60.00	06000	8,850	0	4,689	163	55,394	60.00
65.00	06500	2,812	0	1,904	11	110,575	65.00
66.00	06600	4,039	0	3,067	0	13,832	66.00
71.00	07100	0	0	0	0	1,527,783	71.00
72.00	07200	0	0	0	0	2,633,247	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03020	5,908	0	619	5,272	9,000	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	86	536	186	90.00
90.01	09001	1,893	0	379	6,730	51,732	90.01
91.00	09100	8,836	0	3,405	69,098	277,792	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	7,101	0	7,995	72	83,020	95.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,949	0	0	0	0	190.00
192.00	19200	724	0	75	0	0	192.00
192.01	19201	859	0	0	0	0	192.01
194.00	07950	0	0	440	24	113	194.00
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07951	0	0	0	0	21	194.04
200.00							200.00
201.00							201.00
202.00		893,344	959,583	878,761	1,123,043	1,275,584	202.00
203.00		6.355199	6.562463	17.211709	3.058055	0.191472	203.00
204.00		43,489	153,367	160,307	37,603	230,386	204.00
205.00		0.309378	1.048857	3.139827	0.102393	0.034582	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0275

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

Worksheet B-1
Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description		PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	
		15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
1.01	00101				1.01
2.00	00200				2.00
2.01	00201				2.01
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
7.01	00701				7.01
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
14.00	01400				14.00
15.00	01500	5,469,958			15.00
16.00	01600	0	206,701,795		16.00
17.00	01700	0	0	7,877	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	0	16,039,710	4,735	30.00
31.00	03100	0	3,434,899	173	31.00
43.00	04300	0	813,292	493	43.00
44.00	04400	0	7,541,648	0	44.00
45.00	04500	0	955,012	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	0	15,900,513	2,476	50.00
53.00	05300	0	2,826,227	0	53.00
54.00	05400	0	10,479,765	0	54.00
55.00	05500	0	2,505,877	0	55.00
57.00	05700	0	16,905,163	0	57.00
58.00	05800	0	3,519,154	0	58.00
59.00	05900	0	9,273,846	0	59.00
60.00	06000	0	33,410,691	0	60.00
65.00	06500	0	13,101,224	0	65.00
66.00	06600	0	8,029,689	0	66.00
71.00	07100	0	5,365,576	0	71.00
72.00	07200	0	9,847,223	0	72.00
73.00	07300	5,469,958	19,865,893	0	73.00
76.00	03020	0	871,973	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	0	139,638	0	90.00
90.01	09001	0	3,756,447	0	90.01
91.00	09100	0	22,118,335	0	91.00
92.00	09200				92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		5,469,958	206,701,795	7,877	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	0	0	0	190.00
192.00	19200	0	0	0	192.00
192.01	19201	0	0	0	192.01
194.00	07950	0	0	0	194.00
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
194.04	07951	0	0	0	194.04
200.00					200.00
201.00					201.00
202.00		3,130,425	1,536,057	49,342	202.00
203.00		0.572294	0.007431	6.264060	203.00
204.00		327,165	57,499	15,364	204.00
205.00		0.059811	0.000278	1.950489	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 9:08 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		12,678,186	0	12,678,186	30.00
31.00	03100 INTENSIVE CARE UNIT		1,993,260	0	1,993,260	31.00
43.00	04300 NURSERY		597,674	0	597,674	43.00
44.00	04400 SKILLED NURSING FACILITY		7,028,721	0	7,028,721	44.00
45.00	04500 NURSING FACILITY		620,785	0	620,785	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		5,047,095	0	5,047,095	50.00
53.00	05300 ANESTHESIOLOGY		137,084	0	137,084	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,786,350	0	2,786,350	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		427,872	0	427,872	55.00
57.00	05700 CT SCAN		854,721	0	854,721	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		203,138	0	203,138	58.00
59.00	05900 CARDIAC CATHETERIZATION		1,600,319	0	1,600,319	59.00
60.00	06000 LABORATORY		8,599,374	0	8,599,374	60.00
65.00	06500 RESPIRATORY THERAPY	0	2,118,399	0	2,118,399	65.00
66.00	06600 PHYSICAL THERAPY	0	3,278,292	0	3,278,292	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		2,316,052	0	2,316,052	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT		3,887,847	0	3,887,847	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		10,154,797	0	10,154,797	73.00
76.00	03020 CARDIAC REHAB		1,091,408	0	1,091,408	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		63,196	0	63,196	90.00
90.01	09001 WOUND CENTER		738,868	0	738,868	90.01
91.00	09100 EMERGENCY		4,836,784	0	4,836,784	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1,249,854	0	1,249,854	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES		4,820,005	0	4,820,005	95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		77,130,081	0	77,130,081	200.00
201.00	Less Observation Beds		1,249,854		1,249,854	201.00
202.00	Total (see instructions)		75,880,227	0	75,880,227	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 9:08 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	15,304,221		15,304,221	30.00
31.00	03100	INTENSIVE CARE UNIT	3,724,370		3,724,370	31.00
43.00	04300	NURSERY	779,251		779,251	43.00
44.00	04400	SKILLED NURSING FACILITY	8,054,969		8,054,969	44.00
45.00	04500	NURSING FACILITY	728,277		728,277	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,458,391	10,684,668	17,143,059	0.294410 50.00
53.00	05300	ANESTHESIOLOGY	956,625	1,700,327	2,656,952	0.051594 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,795,865	9,864,732	11,660,597	0.238954 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	462,569	2,085,308	2,547,877	0.167933 55.00
57.00	05700	CT SCAN	5,041,861	16,825,282	21,867,143	0.039087 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	513,549	3,656,102	4,169,651	0.048718 58.00
59.00	05900	CARDIAC CATHETERIZATION	3,744,438	5,695,970	9,440,408	0.169518 59.00
60.00	06000	LABORATORY	10,668,112	28,942,978	39,611,090	0.217095 60.00
65.00	06500	RESPIRATORY THERAPY	8,116,002	5,686,986	13,802,988	0.153474 65.00
66.00	06600	PHYSICAL THERAPY	4,173,161	3,802,209	7,975,370	0.411052 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,793,874	2,981,387	5,775,261	0.401030 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,395,521	2,896,928	9,292,449	0.418388 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,251,924	13,660,203	23,912,127	0.424671 73.00
76.00	03020	CARDIAC REHAB	37,529	965,863	1,003,392	1.087718 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,439	79,798	85,237	0.741415 90.00
90.01	09001	WOUND CENTER	40,340	4,935,983	4,976,323	0.148477 90.01
91.00	09100	EMERGENCY	4,838,975	19,105,610	23,944,585	0.201999 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,913	2,488,405	2,550,318	0.490078 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	10,563,595	10,563,595	0.456285 95.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	94,947,176	146,622,334	241,569,510	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	94,947,176	146,622,334	241,569,510	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 9:08 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.294410		50.00
53.00	05300 ANESTHESIOLOGY	0.051594		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238954		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.167933		55.00
57.00	05700 CT SCAN	0.039087		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.048718		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169518		59.00
60.00	06000 LABORATORY	0.217095		60.00
65.00	06500 RESPIRATORY THERAPY	0.153474		65.00
66.00	06600 PHYSICAL THERAPY	0.411052		66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401030		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.418388		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.424671		73.00
76.00	03020 CARDIAC REHAB	1.087718		76.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.741415		90.00
90.01	09001 WOUND CENTER	0.148477		90.01
91.00	09100 EMERGENCY	0.201999		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.490078		92.00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	0.456285		95.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/28/2017 9:08 am		
		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,678,186		12,678,186	0	12,678,186	30.00
31.00	03100	INTENSIVE CARE UNIT	1,993,260		1,993,260	0	1,993,260	31.00
43.00	04300	NURSERY	597,674		597,674	0	597,674	43.00
44.00	04400	SKILLED NURSING FACILITY	7,028,721		7,028,721	0	7,028,721	44.00
45.00	04500	NURSING FACILITY	620,785		620,785	0	620,785	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,047,095		5,047,095	0	5,047,095	50.00
53.00	05300	ANESTHESIOLOGY	137,084		137,084	0	137,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,786,350		2,786,350	0	2,786,350	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	427,872		427,872	0	427,872	55.00
57.00	05700	CT SCAN	854,721		854,721	0	854,721	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	203,138		203,138	0	203,138	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,600,319		1,600,319	0	1,600,319	59.00
60.00	06000	LABORATORY	8,599,374		8,599,374	0	8,599,374	60.00
65.00	06500	RESPIRATORY THERAPY	2,118,399	0	2,118,399	0	2,118,399	65.00
66.00	06600	PHYSICAL THERAPY	3,278,292	0	3,278,292	0	3,278,292	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,316,052		2,316,052	0	2,316,052	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,887,847		3,887,847	0	3,887,847	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,154,797		10,154,797	0	10,154,797	73.00
76.00	03020	CARDIAC REHAB	1,091,408		1,091,408	0	1,091,408	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	63,196		63,196	0	63,196	90.00
90.01	09001	WOUND CENTER	738,868		738,868	0	738,868	90.01
91.00	09100	EMERGENCY	4,836,784		4,836,784	0	4,836,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,249,854		1,249,854	0	1,249,854	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,820,005		4,820,005	0	4,820,005	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	77,130,081	0	77,130,081	0	77,130,081	200.00
201.00		Less Observation Beds	1,249,854		1,249,854		1,249,854	201.00
202.00		Total (see instructions)	75,880,227	0	75,880,227	0	75,880,227	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/28/2017 9:08 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	15,304,221		15,304,221			30.00
31.00	03100	INTENSIVE CARE UNIT	3,724,370		3,724,370			31.00
43.00	04300	NURSERY	779,251		779,251			43.00
44.00	04400	SKILLED NURSING FACILITY	8,054,969		8,054,969			44.00
45.00	04500	NURSING FACILITY	728,277		728,277			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,458,391	10,684,668	17,143,059	0.294410	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	956,625	1,700,327	2,656,952	0.051594	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,795,865	9,864,732	11,660,597	0.238954	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	462,569	2,085,308	2,547,877	0.167933	0.000000	55.00
57.00	05700	CT SCAN	5,041,861	16,825,282	21,867,143	0.039087	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	513,549	3,656,102	4,169,651	0.048718	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,744,438	5,695,970	9,440,408	0.169518	0.000000	59.00
60.00	06000	LABORATORY	10,668,112	28,942,978	39,611,090	0.217095	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,116,002	5,686,986	13,802,988	0.153474	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	4,173,161	3,802,209	7,975,370	0.411052	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,793,874	2,981,387	5,775,261	0.401030	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,395,521	2,896,928	9,292,449	0.418388	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,251,924	13,660,203	23,912,127	0.424671	0.000000	73.00
76.00	03020	CARDIAC REHAB	37,529	965,863	1,003,392	1.087718	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	5,439	79,798	85,237	0.741415	0.000000	90.00
90.01	09001	WOUND CENTER	40,340	4,935,983	4,976,323	0.148477	0.000000	90.01
91.00	09100	EMERGENCY	4,838,975	19,105,610	23,944,585	0.201999	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	61,913	2,488,405	2,550,318	0.490078	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	10,563,595	10,563,595	0.456285	0.000000	95.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	94,947,176	146,622,334	241,569,510			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	94,947,176	146,622,334	241,569,510			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 9:08 am
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44.00
45.00	04500 NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000			55.00
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03020 CARDIAC REHAB	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 WOUND CENTER	0.000000			90.01
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				113.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part I Date/Time Prepared: 11/28/2017 9:08 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,189,276	0	1,189,276	11,432	104.03	30.00
31.00	INTENSIVE CARE UNIT	162,575		162,575	1,070	151.94	31.00
43.00	NURSERY	38,621		38,621	894	43.20	43.00
44.00	SKILLED NURSING FACILITY	417,535		417,535	26,628	15.68	44.00
45.00	NURSING FACILITY	93,892		93,892	4,166	22.54	45.00
200.00	Total (Lines 30-199)	1,901,899		1,901,899	44,190		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,229	439,943				
31.00	INTENSIVE CARE UNIT	433	65,790				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	4,423	69,353				
45.00	NURSING FACILITY	0	0				
200.00	Total (Lines 30-199)	9,085	575,086				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/28/2017 9:08 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)	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	689,442	17,143,059	0.040217	2,396,066	96,363	50.00
53.00	05300	ANESTHESIOLOGY	61,043	2,656,952	0.022975	339,782	7,806	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,289	11,660,597	0.037158	619,852	23,032	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,322	2,547,877	0.005229	203,998	1,067	55.00
57.00	05700	CT SCAN	260,236	21,867,143	0.011901	1,307,929	15,566	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	17,300	4,169,651	0.004149	162,481	674	58.00
59.00	05900	CARDIAC CATHETERIZATION	179,611	9,440,408	0.019026	1,343,994	25,571	59.00
60.00	06000	LABORATORY	659,157	39,611,090	0.016641	3,584,150	59,644	60.00
65.00	06500	RESPIRATORY THERAPY	204,636	13,802,988	0.014825	2,993,960	44,385	65.00
66.00	06600	PHYSICAL THERAPY	338,641	7,975,370	0.042461	662,421	28,127	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,039	5,775,261	0.025806	1,656,570	42,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	138,791	9,292,449	0.014936	3,183,848	47,554	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	426,142	23,912,127	0.017821	4,440,889	79,141	73.00
76.00	03020	CARDIAC REHAB	212,866	1,003,392	0.212146	14,775	3,134	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,269	85,237	0.026620	1,955	52	90.00
90.01	09001	WOUND CENTER	92,389	4,976,323	0.018566	25,694	477	90.01
91.00	09100	EMERGENCY	320,161	23,944,585	0.013371	2,225,493	29,757	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	117,243	2,550,318	0.045972	1,744	80	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	4,315,577	202,414,827		25,165,601	505,179	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part III Date/Time Prepared: 11/28/2017 9:08 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,432	0.00	4,229	0		30.00
31.00	03100	INTENSIVE CARE UNIT	1,070	0.00	433	0		31.00
43.00	04300	NURSERY	894	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	26,628	0.00	4,423	0		44.00
45.00	04500	NURSING FACILITY	4,166	0.00	0	0		45.00
200.00		Total (lines 30-199)	44,190		9,085	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:08 am
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Cost Center Description	Title XVIII			Hospital	PPS	Total Cost (sum of col 1 through col. 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost			
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03020	CARDIAC REHAB	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CENTER	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:08 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	17,143,059	0.000000	0.000000	2,396,066	50.00
53.00	05300	ANESTHESIOLOGY	0	2,656,952	0.000000	0.000000	339,782	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,660,597	0.000000	0.000000	619,852	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,547,877	0.000000	0.000000	203,998	55.00
57.00	05700	CT SCAN	0	21,867,143	0.000000	0.000000	1,307,929	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	4,169,651	0.000000	0.000000	162,481	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,440,408	0.000000	0.000000	1,343,994	59.00
60.00	06000	LABORATORY	0	39,611,090	0.000000	0.000000	3,584,150	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,802,988	0.000000	0.000000	2,993,960	65.00
66.00	06600	PHYSICAL THERAPY	0	7,975,370	0.000000	0.000000	662,421	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,775,261	0.000000	0.000000	1,656,570	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,292,449	0.000000	0.000000	3,183,848	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,912,127	0.000000	0.000000	4,440,889	73.00
76.00	03020	CARDIAC REHAB	0	1,003,392	0.000000	0.000000	14,775	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	85,237	0.000000	0.000000	1,955	90.00
90.01	09001	WOUND CENTER	0	4,976,323	0.000000	0.000000	25,694	90.01
91.00	09100	EMERGENCY	0	23,944,585	0.000000	0.000000	2,225,493	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,550,318	0.000000	0.000000	1,744	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	202,414,827			25,165,601	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:08 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)	
		11.00	12.00	13.00	
Title XVIII					
Hospital					
PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	2,391,632	0	50.00
53.00	05300 ANESTHESIOLOGY	0	316,706	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	1,544,598	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	457,313	0	55.00
57.00	05700 CT SCAN	0	4,006,611	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	663,579	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	2,539,811	0	59.00
60.00	06000 LABORATORY	0	2,962,009	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,491,694	0	65.00
66.00	06600 PHYSICAL THERAPY	0	41,580	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	810,639	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	812,293	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,383,720	0	73.00
76.00	03020 CARDIAC REHAB	0	387,476	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	528	0	90.00
90.01	09001 WOUND CENTER	0	1,932,936	0	90.01
91.00	09100 EMERGENCY	0	2,394,076	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	208,315	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (lines 50-199)	0	27,345,516	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 9:08 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	0.294410	2,391,632	0	0	704,120	50.00
53.00	05300	ANESTHESIOLOGY	0.051594	316,706	0	0	16,340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.238954	1,544,598	0	0	369,088	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.167933	457,313	0	0	76,798	55.00
57.00	05700	CT SCAN	0.039087	4,006,611	0	0	156,606	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.048718	663,579	0	0	32,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.169518	2,539,811	0	0	430,544	59.00
60.00	06000	LABORATORY	0.217095	2,962,009	0	1,122	643,037	60.00
65.00	06500	RESPIRATORY THERAPY	0.153474	1,491,694	0	0	228,936	65.00
66.00	06600	PHYSICAL THERAPY	0.411052	41,580	0	0	17,092	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401030	810,639	0	0	325,091	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.418388	812,293	0	0	339,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.424671	4,383,720	0	9,486	1,861,639	73.00
76.00	03020	CARDIAC REHAB	1.087718	387,476	0	0	421,465	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.741415	528	0	0	391	90.00
90.01	09001	WOUND CENTER	0.148477	1,932,936	0	0	286,997	90.01
91.00	09100	EMERGENCY	0.201999	2,394,076	0	0	483,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.490078	208,315	0	0	102,091	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.456285		0	0		95.00
200.00		Subtotal (see instructions)		27,345,516	0	10,608	6,496,018	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		27,345,516	0	10,608	6,496,018	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 9:08 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
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	244		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,028		73.00
76.00 03020 CARDIAC REHAB	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CENTER	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0			95.00
200.00 Subtotal (see instructions)	0	4,272		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	4,272		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:08 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020 CARDIAC REHAB	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 WOUND CENTER	0	0	0	0	0	90.01
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							
95.00	09500 AMBULANCE SERVICES						95.00
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: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:08 am
Title XVIII		Skilled Nursing Facility	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	17,143,059	0.000000	0.000000	0	50.00
53.00	05300 ANESTHESIOLOGY	0	2,656,952	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	11,660,597	0.000000	0.000000	17,567	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	2,547,877	0.000000	0.000000	0	55.00
57.00	05700 CT SCAN	0	21,867,143	0.000000	0.000000	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	4,169,651	0.000000	0.000000	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	9,440,408	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	39,611,090	0.000000	0.000000	99,146	60.00
65.00	06500 RESPIRATORY THERAPY	0	13,802,988	0.000000	0.000000	68,256	65.00
66.00	06600 PHYSICAL THERAPY	0	7,975,370	0.000000	0.000000	1,456,684	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,775,261	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	9,292,449	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	23,912,127	0.000000	0.000000	339,466	73.00
76.00	03020 CARDIAC REHAB	0	1,003,392	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	85,237	0.000000	0.000000	0	90.00
90.01	09001 WOUND CENTER	0	4,976,323	0.000000	0.000000	0	90.01
91.00	09100 EMERGENCY	0	23,944,585	0.000000	0.000000	73,320	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,550,318	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50-199)	0	202,414,827			2,054,439	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 9:08 am
Title XVIII		Skilled Nursing Facility	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
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00	03020 CARDIAC REHAB	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 WOUND CENTER	0	0	0	90.01
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					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (Lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 9:08 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)		11,432	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,432	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)		10,305	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)		4,229	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)		12,678,186	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)		12,678,186	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)		12,678,186	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)		1,109.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,690,003	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)		4,690,003	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 9:08 am		
Cost Center Description			Title XVIII		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	1,993,260	1,070	1,862.86	433	806,618	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)					7,056,158	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,552,779	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)					505,733	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					505,179	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,010,912	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					11,541,867	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,127	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,109.01	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,249,854	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 9:08 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,189,276	12,678,186	0.093805	1,249,854	117,243	90.00
91.00	Nursing School cost	0	12,678,186	0.000000	1,249,854	0	91.00
92.00	Allied health cost	0	12,678,186	0.000000	1,249,854	0	92.00
93.00	All other Medical Education	0	12,678,186	0.000000	1,249,854	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 9:08 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		26,628	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		26,628	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)		26,628	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)		4,423	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)		7,028,721	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)		7,028,721	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)		7,028,721	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 9:08 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)	
42.00	NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT							43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							54.00
55.00	Target amount per discharge							55.00
56.00	Target amount (line 54 x line 55)							56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00
58.00	Bonus payment (see instructions)							58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61.00
62.00	Relief payment (see instructions)							62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						7,028,721	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						263.96	71.00
72.00	Program routine service cost (line 9 x line 71)						1,167,495	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						1,167,495	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)						0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0	80.00
81.00	Inpatient routine service cost per diem limitation						0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)						1,167,495	83.00
84.00	Program inpatient ancillary services (see instructions)						793,943	84.00
85.00	Utilization review - physician compensation (see instructions)						0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						1,961,438	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: 14-0275 Component CCN: 14-5703		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 9:08 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 9:08 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		5,051,622		30.00
31.00	03100 INTENSIVE CARE UNIT		1,391,020		31.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.294410	2,396,066	705,426	50.00
53.00	05300 ANESTHESIOLOGY	0.051594	339,782	17,531	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238954	619,852	148,116	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.167933	203,998	34,258	55.00
57.00	05700 CT SCAN	0.039087	1,307,929	51,123	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.048718	162,481	7,916	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169518	1,343,994	227,831	59.00
60.00	06000 LABORATORY	0.217095	3,584,150	778,101	60.00
65.00	06500 RESPIRATORY THERAPY	0.153474	2,993,960	459,495	65.00
66.00	06600 PHYSICAL THERAPY	0.411052	662,421	272,289	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401030	1,656,570	664,334	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.418388	3,183,848	1,332,084	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.424671	4,440,889	1,885,917	73.00
76.00	03020 CARDIAC REHAB	1.087718	14,775	16,071	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.741415	1,955	1,449	90.00
90.01	09001 WOUND CENTER	0.148477	25,694	3,815	90.01
91.00	09100 EMERGENCY	0.201999	2,225,493	449,547	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.490078	1,744	855	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		25,165,601	7,056,158	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)		25,165,601		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 9:08 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.294410	0	50.00
53.00	05300 ANESTHESIOLOGY	0.051594	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.238954	17,567	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.167933	0	55.00
57.00	05700 CT SCAN	0.039087	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.048718	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.169518	0	59.00
60.00	06000 LABORATORY	0.217095	99,146	60.00
65.00	06500 RESPIRATORY THERAPY	0.153474	68,256	65.00
66.00	06600 PHYSICAL THERAPY	0.411052	1,456,684	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.401030	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.418388	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.424671	339,466	73.00
76.00	03020 CARDIAC REHAB	1.087718	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.741415	0	90.00
90.01	09001 WOUND CENTER	0.148477	0	90.01
91.00	09100 EMERGENCY	0.201999	73,320	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.490078	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES			95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		2,054,439	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)		2,054,439	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 9:08 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)		2,546,283	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		7,638,848	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)		63,922	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		5,617,372	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		141.91	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)		3.74	30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.26	31.00
32.00	Sum of lines 30 and 31		26.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.67	33.00
34.00	Disproportionate share adjustment (see instructions)		271,688	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 9:08 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		585,264	593,434	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		147,115	443,856	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		590,971		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)		11,111,712		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)			11,111,712	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			873,714	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			1,588	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			11,987,014	59.00
60.00	Primary payer payments			4,391	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			11,982,623	61.00
62.00	Deductibles billed to program beneficiaries			1,368,892	62.00
63.00	Coinurance billed to program beneficiaries			17,892	63.00
64.00	Allowable bad debts (see instructions)			186,678	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			121,341	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			174,895	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10,717,180	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	RURAL DEMONSTRATION PROJECT			0	70.50
70.88	SCH or MDH volume decrease adjustment			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			1,740	70.93
70.94	HRR adjustment amount (see instructions)			-21,048	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 9:08 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			10,697,872	71.00
71.01	Sequestration adjustment (see instructions)			213,957	71.01
72.00	Interim payments			10,449,008	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)			34,907	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 9:08 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		4,272	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,496,018	2.00
3.00	PPS payments		6,328,837	3.00
4.00	Outlier payment (see instructions)		24,660	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.274	5.00
6.00	Line 2 times line 5		1,779,909	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)		4,272	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,608	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)		10,608	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)		10,608	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		6,336	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)		4,272	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)		6,353,497	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)		1,234,355	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)		5,123,414	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)		5,123,414	30.00
31.00	Primary payer payments		9,452	31.00
32.00	Subtotal (line 30 minus line 31)		5,113,962	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)		158,102	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		102,766	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		135,169	36.00
37.00	Subtotal (see instructions)		5,216,728	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)		5,216,728	40.00
40.01	Sequestration adjustment (see instructions)		104,335	40.01
41.00	Interim payments		5,145,249	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-32,856	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: 14-0275		Period: From 07/01/2016 To 06/30/2017		Worksheet E-1 Part I Date/Time Prepared: 11/28/2017 9:08 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		10,449,008		5,145,249		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)		10,449,008		5,145,249		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		34,907		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		32,856		6.02
7.00	Total Medicare program liability (see instructions)		10,483,915		5,112,393		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: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part I Date/Time Prepared: 11/28/2017 9:08 am		
		Title XVIII	Skilled Nursing Facility	PPS		
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider				0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,911,169		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,911,169		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,911,169		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/28/2017 9:08 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		4,123	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		4,662	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		2,632	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		11,375	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		241,569,510	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		3,665,442	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)		422,369	8.00
9.00	Sequestration adjustment amount (see instructions)		8,447	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		413,922	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		413,922	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0275 Component CCN: 14-5703	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VI Date/Time Prepared: 11/28/2017 9:08 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,146,681	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,146,681	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		196,336	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,950,345	12.00
13.00	Inpatient primary payer payments		173	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		1,950,172	15.00
15.01	Sequestration adjustment (see instructions)		39,003	15.01
16.00	Interim payments		1,911,169	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0275

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

Worksheet G

Date/Time Prepared:
11/28/2017 9:08 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	24,459,399	0	0	0	1.00
2.00	Temporary investments	664,859	0	0	0	2.00
3.00	Notes receivable	1,807,025	0	0	0	3.00
4.00	Accounts receivable	46,926,773	0	0	0	4.00
5.00	Other receivable	516,332	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-30,995,303	0	0	0	6.00
7.00	Inventory	2,626,800	0	0	0	7.00
8.00	Prepaid expenses	472,983	0	0	0	8.00
9.00	Other current assets	2,579,583	0	0	0	9.00
10.00	Due from other funds	1,520,472	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	50,578,923	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,374,122	0	0	0	12.00
13.00	Land improvements	5,043,535	0	0	0	13.00
14.00	Accumulated depreciation	-2,085,065	0	0	0	14.00
15.00	Buildings	66,573,744	0	0	0	15.00
16.00	Accumulated depreciation	-40,199,145	0	0	0	16.00
17.00	Leasehold improvements	2,090,594	0	0	0	17.00
18.00	Accumulated depreciation	-359,334	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	50,096,252	0	0	0	23.00
24.00	Accumulated depreciation	-42,415,602	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	41,119,101	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	8,954,270	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,954,270	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	100,652,294	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,959,989	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,647,135	0	0	0	38.00
39.00	Payroll taxes payable	1,101,199	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,761,687	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	1,814,669	0	0	0	43.00
44.00	Other current liabilities	4,594,666	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	12,879,345	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	5,326,899	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,326,899	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	18,206,244	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	82,446,050				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	82,446,050	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	100,652,294	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0275

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

Worksheet G-1

Date/Time Prepared:
11/28/2017 9:08 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		75,987,787		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		6,138,394			2.00
3.00	Total (sum of line 1 and line 2)		82,126,181		0	3.00
4.00	ADDITIONS	276,945		0		4.00
5.00	ROUNDING	42,924		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		319,869		0	10.00
11.00	Subtotal (line 3 plus line 10)		82,446,050		0	11.00
12.00	DEDUCTIONS	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		82,446,050		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		0			4.00
5.00	ROUNDING		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		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0275

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2017 9:08 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	13,146,085		13,146,085	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	7,150,616		7,150,616	7.00
8.00	NURSING FACILITY	728,277		728,277	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	21,024,978		21,024,978	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,418,466		3,418,466	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)	3,418,466		3,418,466	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	24,443,444		24,443,444	17.00
18.00	Ancillary services	72,271,929	159,017,501	231,289,430	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	722,252	722,252	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CROSSTOWN SQUARE	985,186	0	985,186	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	97,700,559	159,739,753	257,440,312	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		93,986,791		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	INCOME TAX	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)		93,986,791		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0275

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

Worksheet G-3

Date/Time Prepared:
11/28/2017 9:08 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	257,440,312	1.00
2.00	Less contractual allowances and discounts on patients' accounts	152,509,102	2.00
3.00	Net patient revenues (line 1 minus line 2)	104,931,210	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	93,986,791	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,944,419	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	2,953,972	24.00
24.01	BAD DEBTS	-4,598,748	24.01
24.02	CHARITY CARE	-3,665,442	24.02
24.03	NONOPERATING GAINS & LOSSES	563,651	24.03
24.04	ROUNDING	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
25.00	Total other income (sum of lines 6-24)	-4,746,567	25.00
26.00	Total (line 5 plus line 25)	6,197,852	26.00
27.00	COGS	59,458	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	59,458	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	6,138,394	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0275	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/28/2017 9:08 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		819,979	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		9,374	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)		31.59	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.74	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.26	8.00
9.00	Sum of lines 7 and 8		26.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.41	10.00
11.00	Disproportionate share adjustment (see instructions)		44,361	11.00
12.00	Total prospective capital payments (see instructions)		873,714	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