

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: 14-0292	Period: From 01/01/2017 To 12/31/2017	worksheet 5 Parts I-III Date/Time Prepared 5/29/2018 9:45 am
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PART I - COST REPORT STATUS

Date: 5/29/2018 Time: 9:45 a

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report
	2. <input type="checkbox"/> Manually submitted cost report
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report
	4. <input type="checkbox"/> Medicare utilization. Enter "F" for full or "L" for low.
Contractor use only	5. <input type="checkbox"/> Cost Report Status
	(1) As Submitted
	(2) Settled without Audit
	(3) Settled with Audit
	(4) Reopened
	6. Date Received:
	7. Contractor No.
	8. <input type="checkbox"/> Initial Report for this Provider CCN
	9. <input type="checkbox"/> Final Report for this Provider CCN
	10. NPR Date:
	11. Contractor's Vendor Code: 4
	12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ADVENTIST GLENOAKS HOSPITAL (14-0292) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Encryption Information

ECR: Date: 5/29/2018 Time: 9:45 am
TUGpGbzkhkvoPoyRZRau0JmgtLVx80
wbs6v0q8ZTmJSxOvvMhZAA3jG7AN2
vizglU9jN50VuwTT
PI: Date: 5/29/2018 Time: 9:45 am
8HvudrFeQN00.iaekyufX7.19xVMF0
K5ph10EIVt8AW1Q9CMEmlVJpHd011
q4wB059Ynu0p:kdw

Title

Date

President/CEO
5/29/2018

	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	-29,178	-47,564	0	0	1.0
2.00 Subprovider - IPF	0	26,569	0	0	0	2.0
3.00 Subprovider - IRF	0	0	0	0	0	3.0
5.00 Swing bed - SNF	0	0	0	0	0	5.0
6.00 Swing bed - NF	0	0	0	0	0	6.0
200.00 Total	0	-2,609	-47,564	0	0	200.0

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.

		1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 701 WINTHROP AVENUE	PO Box:		Zip Code: 60139-		County: DUPAGE				1.00	
2.00	City: GLENDALE HEIGHTS	State: IL								2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
		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	ADVENTIST GLENOAKS HOSPITAL	140292	16974	1	11/23/1982	N	P	O	3.00	
4.00	Subprovider - IPF	GLEN OAKS MED CTR PSYCH UNIT	14S292	16974	4	01/01/1984	N	P	T	4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF									9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA									12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC									15.00	
16.00	Hospital-Based Health Clinic - FQHC									16.00	
17.00	Hospital-Based (CMHC) I									17.00	
18.00	Renal Dialysis									18.00	
19.00	Other									19.00	
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2017	12/31/2017		20.00	
21.00	Type of Control (see instructions)						1			21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							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.	1,437	1,644	0	69	6,907	96		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00		

Health Financial Systems

ADVENTIST GLENOAKS HOSPITAL

Provider CCN: 14-0292

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

Worksheet S-2
Part I
Date/Time Prepared:
5/29/2018 9:38 am

		Urban/Rural S	Date of Geogr			
		1.00	2.00		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.		0			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.	N				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	Y		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete wkst. L, Pt. III and wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85	worksheet A	Pass-Through		
		Y/N	Line #	Qualification		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N				60.00
		Y/N	IME	Direct GME		
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				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. Enter in column 4, the 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 through 67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
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
		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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0292	Period: From 01/01/2017 To 12/31/2017	worksheet S-2 Part I Date/Time Prepared: 5/29/2018 9:38 am		
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N		86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00	
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title v and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y	90.00	
91.00	Is this hospital reimbursed for title v and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title v and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N	93.00	
94.00	Does title v or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00	
96.00	Does title v or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00	
98.00	Does title v or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title v, and in column 2 for title XIX.	Y	Y		98.00	
98.01	Does title v or XIX follow Medicare (title XVIII) for the reporting of charges on wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title v, and in column 2 for title XIX.	Y	Y		98.01	
98.02	Does title v or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title v, and in column 2 for title XIX.	Y	Y		98.02	
98.03	Does title v or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title v, and in column 2 for title XIX.	N	N		98.03	
98.04	Does title v or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title v, and in column 2 for title XIX.	N	N		98.04	
98.05	Does title v or XIX follow Medicare (title XVIII) and add back the RCE disallowance on wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title v, and in column 2 for title XIX.	Y	Y		98.05	
98.06	Does title v or XIX follow Medicare (title XVIII) when cost reimbursed for wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title v, and in column 2 for title XIX.	Y	Y		98.06	
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete wkst. D-2, Pt. II.				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00	
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	N
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete worksheet E, Part A, lines 200 through 218, and worksheet E-2, lines 200 through 215, as applicable.			N		110.00

Health Financial Systems		ADVENTIST GLENOAKS HOSPITAL		In Lieu of Form CMS-2552-1f		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0292	Period: From 01/01/2017 To 12/31/2017	worksheet S-2 Part I Date/Time Prepared: 5/29/2018 9:38 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
			1.00	2.00	3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	736,147	0		0	118.01
			1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the worksheet A line number where these taxes are included.	N				122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			HF8013	140.00

		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00	
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00	
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N		4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00	
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00	
8.00	were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00	
10.00	was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00	
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00	
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N		15.00	
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2018	Y	04/03/2018
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	
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	

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MIKE		THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	ADVENTIST HEALTH SYSTEM SUNBELT			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	407-357-2338		MIKE.THOMPSON3@AHSS.ORG	43.00

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	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

Provider CCN: 14-0292

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

Worksheet S-2
Part V
Date/Time Prepared:
5/29/2018 9:38 am

1.00

Cost Report Preparer Contact Information

1.00	First Name	MIKE	1.00
2.00	Last Name	THOMPSON	2.00
3.00	Title	REIMBURSEMENT MANAGER	3.00
4.00	Employer	ADVENTIST HEALTH SYSTEM SUNBELT (407) 357-2338	4.00
5.00	Phone Number		5.00
6.00	E-mail Address	MIKE.THOMPSON3@AHSS.ORG	6.00
7.00	Department	CORPORATE REIMBURSEMENT	7.00
8.00	Mailing Address 1	900 HOPE WAY	8.00
9.00	Mailing Address 2		9.00
10.00	City	ALTAMONTE SPRING	10.00
11.00	State	FL	11.00
12.00	Zip	32714	12.00

Officer or Administrator of Provider Contact Information

13.00	First Name		13.00
14.00	Last Name		14.00
15.00	Title		15.00
16.00	Employer		16.00
17.00	Phone Number		17.00
18.00	E-mail Address		18.00
19.00	Department		19.00
20.00	Mailing Address 1		20.00
21.00	Mailing Address 2		21.00
22.00	City		22.00
23.00	State		23.00
24.00	Zip		24.00

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/s B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/s C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of observation Bed Cost on w/s D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use w/s D-1 for reimbursement?	N	N	3.01
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/s C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "o") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	Title V
	Line Number					
	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	117	42,705	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		117	42,705	0.00	0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)					0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	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)		127	46,355	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	16	5,840		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		143			0	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		0	0			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
33.01 LTCH site neutral days and discharges						33.01

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	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)	6,840	1,264	22,154			1.00
2.00 HMO and other (see instructions)	1,617	8,716				2.00
3.00 HMO IPF Subprovider	196	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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	6,840	1,264	22,154			7.00
8.00 INTENSIVE CARE UNIT	930	59	2,534			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		89	613			13.00
14.00 Total (see instructions)	7,770	1,412	25,301	0.00	667.26	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,848	43	4,425	0.00	49.52	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	1	0	36			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	716.78	27.00
28.00 Observation Bed Days		54	1,400			28.00
29.00 Ambulance Trips	0		57			29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	25	78			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	1,415	441	5,338	1.00
2.00 HMO and other (see instructions)				338	1,582		2.00
3.00 HMO IPF Subprovider					30		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		1,415	441	5,338	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0		224	4	398	16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0292

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

Worksheet 5-3
Part II
Date/Time Prepared:
5/29/2018 9:38 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	36,868,002	8,500	36,876,502	1,553,130.00	23.74 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		114,571	0	114,571	1,626.00	70.46 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		261,546	0	261,546	4,323.00	60.50 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		6,636,312	0	6,636,312	260,821.00	25.44 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		745,704	0	745,704	16,844.00	44.27 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		264,431	0	264,431	2,082.00	127.01 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		2,999,960	0	2,999,960	49,586.00	60.50 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)		5,672,479	0	5,672,479		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,202,505	0	1,202,505		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		13,515	0	13,515		
24.00	wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		809,513	0	809,513		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,105,922	8,500	1,114,422	2,150.00	518.34 26.00
27.00	Administrative & General	5.00	3,069,074	0	3,069,074	74,422.00	41.24 27.00

	wkst. A Line Number	Amount Reported	Reclassification of Salaries (from wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	32,804	0	32,804	188.00	174.49	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	916,910	0	916,910	57,451.00	15.96	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	0	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	2,198,475	0	2,198,475	60,901.00	36.10	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	1,351,706	0	1,351,706	53,301.00	25.36	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,144,703	0	1,144,703	36,198.00	31.62	38.00
39.00	Central Services and Supply	235,668	0	235,668	19,697.00	11.96	39.00
40.00	Pharmacy	1,474,801	0	1,474,801	46,668.00	31.60	40.00
41.00	Medical Records & Medical Records Library	265,560	0	265,560	16,675.00	15.93	41.00
42.00	Social Service	518,147	0	518,147	14,393.00	36.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	40,074,870	8,500	40,083,370	1,661,571.00	24.12	1.00
2.00	Excluded area salaries (see instructions)	6,636,312	0	6,636,312	260,821.00	25.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)	33,438,558	8,500	33,447,058	1,400,750.00	23.88	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,010,095	0	4,010,095	68,512.00	58.53	4.00
5.00	Subtotal wage-related costs (see inst.)	6,481,992	0	6,481,992	0.00	19.38	5.00
6.00	Total (sum of lines 3 thru 5)	43,930,645	8,500	43,939,145	1,469,262.00	29.91	6.00
7.00	Total overhead cost (see instructions)	12,313,770	8,500	12,322,270	382,044.00	32.25	7.00

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	896,605	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)	3,107,075	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	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	33,323	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'workers' Compensation Insurance	202,642	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	2,554,699	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	3,742	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	90,413	23.00
24.00	Total wage Related cost (Sum of lines 1 -23)	6,888,499	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: 14-0292

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

Worksheet S-3
Part V
Date/Time Prepared:
5/29/2018 9:38 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	745,704	6,888,499	1.00
2.00	Hospital	745,704	6,888,499	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0292	Period: From 01/01/2017 To 12/31/2017	Worksheet S-10 Date/Time Prepared: 5/29/2018 9:38 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)		0.270289	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		25,355,983	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		86,125,551	6.00
7.00	Medicaid cost (line 1 times line 6)		23,278,789	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		23,646	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)	5,219,270	486,210	5,705,480
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,410,711	486,210	1,896,921
22.00	Payments received from patients for amounts previously written off as charity care	7,016	0	7,016
23.00	Cost of charity care (line 21 minus line 22)	1,403,695	486,210	1,889,905
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		3,601,153	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		279,406	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		429,855	27.01
28.00	Non-Medicare bad debt expense (see instructions)		3,171,298	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,007,616	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,897,521	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,897,521	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0292

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

Worksheet A

Date/Time Prepared:
5/29/2018 9:38 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		0	0	2,138,932	2,138,932	1.00
2.00	00200		0	0	1,518,538	1,518,538	2.00
4.00	00400	1,105,922	3,452,167	4,558,089	-120	4,557,969	4.00
5.01	01160	0	79,346	79,346	-5,101	74,245	5.01
5.04	00570	747,220	142,375	889,595	-20	889,575	5.04
5.06	00560	2,321,854	23,370,018	25,691,872	-85,414	25,606,458	5.06
7.00	00700	916,910	2,082,242	2,999,152	-540	2,998,612	7.00
9.00	00900	0	1,774,601	1,774,601	-1,660	1,772,941	9.00
10.00	01000	0	2,099,141	2,099,141	-1,251,972	847,169	10.00
11.00	01100	0	0	0	1,251,088	1,251,088	11.00
13.00	01300	1,144,703	306,114	1,450,817	-660	1,450,157	13.00
14.00	01400	235,668	325,373	561,041	-247,149	313,892	14.00
15.00	01500	1,474,801	2,770,855	4,245,656	-2,580,776	1,664,880	15.00
16.00	01600	265,560	10,654	276,214	0	276,214	16.00
17.00	01700	518,147	197,922	716,069	-20	716,049	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	9,476,348	1,386,170	10,862,518	-1,002,692	9,859,826	30.00
31.00	03100	2,136,616	674,467	2,811,083	-47,314	2,763,769	31.00
40.00	04000	2,202,871	248,413	2,451,284	-16,798	2,434,486	40.00
43.00	04300	0	5,454	5,454	534,007	539,461	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,373,992	1,472,722	2,846,714	-912,672	1,934,042	50.00
51.00	05100	236,368	17,820	254,188	-190	253,998	51.00
52.00	05200	633,068	658,710	1,291,778	237,601	1,529,379	52.00
53.00	05300	49,250	53,122	102,372	-8,049	94,323	53.00
54.00	05400	918,661	298,662	1,217,323	-14,669	1,202,654	54.00
56.00	05600	152,050	45,283	197,333	-30,435	166,898	56.00
57.00	05700	428,112	89,977	518,089	-54,808	463,281	57.00
58.00	05800	148,670	15,853	164,523	-5,371	159,152	58.00
59.00	05900	716,923	1,621,709	2,338,632	-1,310,378	1,028,254	59.00
60.00	06000	1,374,876	1,324,882	2,699,758	-491,693	2,208,065	60.00
65.00	06500	729,991	219,094	949,085	-87,481	861,604	65.00
66.00	06600	0	1,227,832	1,227,832	-113,439	1,114,393	66.00
67.00	06700	0	175,465	175,465	-90	175,375	67.00
68.00	06800	0	46,450	46,450	0	46,450	68.00
69.00	06900	342,251	172,543	514,794	-9,874	504,920	69.00
70.00	07000	26,791	1,709	28,500	0	28,500	70.00
71.00	07100	0	40,622	40,622	2,431,812	2,472,434	71.00
72.00	07200	0	331,553	331,553	1,179,084	1,510,637	72.00
73.00	07300	0	35	35	2,502,920	2,502,955	73.00
74.00	07400	0	335,356	335,356	0	335,356	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	5,146	94,268	99,414	-7,934	91,480	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	390,756	62,029	452,785	-15,536	437,249	90.00
91.00	09100	2,361,036	2,237,256	4,598,292	-344,715	4,253,577	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		2,873,174	2,873,174	-3,146,412	-273,238	113.00
118.00		32,434,561	52,341,438	84,775,999	0	84,775,999	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	45,292	10,085	55,377	0	55,377	190.00
192.00	19200	0	2,067,080	2,067,080	0	2,067,080	192.00
192.03	19203	164,441	677,810	842,251	0	842,251	192.03
194.00	07950	166,483	37,130	203,613	0	203,613	194.00
194.01	07951	0	3,286	3,286	0	3,286	194.01
194.03	07953	4,057,225	1,326,215	5,383,440	0	5,383,440	194.03
200.00		36,868,002	56,463,044	93,331,046	0	93,331,046	200.00

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	-340,838	1,798,094	1.00
2.00	00200	112,647	1,631,185	2.00
4.00	00400	82,712	4,640,681	4.00
5.01	01160	-23,875	50,370	5.01
5.04	00570	-18,946	870,629	5.04
5.06	00560	-7,672,449	17,934,009	5.06
7.00	00700	-16,924	2,981,688	7.00
9.00	00900	-272	1,772,669	9.00
10.00	01000	-395,713	451,456	10.00
11.00	01100	0	1,251,088	11.00
13.00	01300	-3,288	1,446,869	13.00
14.00	01400	-1,011	312,881	14.00
15.00	01500	0	1,664,880	15.00
16.00	01600	8,001	284,215	16.00
17.00	01700	-4,000	712,049	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	-30,878	9,828,948	30.00
31.00	03100	-10,367	2,753,402	31.00
40.00	04000	0	2,434,486	40.00
43.00	04300	0	539,461	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	-33	1,934,009	50.00
51.00	05100	0	253,998	51.00
52.00	05200	-490,643	1,038,736	52.00
53.00	05300	0	94,323	53.00
54.00	05400	-120,992	1,081,662	54.00
56.00	05600	0	166,898	56.00
57.00	05700	0	463,281	57.00
58.00	05800	0	159,152	58.00
59.00	05900	-75,659	952,595	59.00
60.00	06000	-1,474	2,206,591	60.00
65.00	06500	-3,950	857,654	65.00
66.00	06600	-130	1,114,263	66.00
67.00	06700	0	175,375	67.00
68.00	06800	0	46,450	68.00
69.00	06900	-212,294	292,626	69.00
70.00	07000	0	28,500	70.00
71.00	07100	-3	2,472,431	71.00
72.00	07200	0	1,510,637	72.00
73.00	07300	-6,831	2,496,124	73.00
74.00	07400	-300	335,056	74.00
76.00	03050	0	0	76.00
76.01	03060	0	91,480	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	-37,855	399,394	90.00
91.00	09100	-1,460,079	2,793,498	91.00
92.00	09200			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	273,238	0	113.00
118.00		-10,452,206	74,323,793	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	0	55,377	190.00
192.00	19200	0	2,067,080	192.00
192.03	19203	0	842,251	192.03
194.00	07950	0	203,613	194.00
194.01	07951	0	3,286	194.01
194.03	07953	0	5,383,440	194.03
200.00		-10,452,206	82,878,840	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0292

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

Worksheet Non-CMS W

Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	COMMUNICATIONS	01160	COMMUNICATIONS	5.01
5.04	ADMITTING	00570	ADMITTING	5.04
5.06	OTHER ADMINISTRATIVE AND GENERAL	00560	PURCHASING RECEIVING AND STORES	5.06
7.00	OPERATION OF PLANT	00700		7.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
43.00	NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
76.00	BACTERIOLOGY & MICROBIOLOGY	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	WOUND CARE	03060	BIOPSY	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	09000		90.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
192.03	OP PHARMACY	19203		192.03
194.00	FOUNDATION	07950		194.00
194.01	MARKETING	07951		194.01
194.03	THERAPEUTIC DAY SCHOOL	07953		194.03
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

	Cost Center 2.00	Increases		Other 5.00	
		Line # 3.00	Salary 4.00		
A - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,430,092	1.00
2.00	PHARMACY	15.00	0	27,505	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
0			0	2,457,597	
B - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,251,088	1.00
0			0	1,251,088	
C - NURSERY					
1.00	NURSERY	43.00	380,786	156,925	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	472,528	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	30,324	3.00
0			853,314	187,249	
D - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	111,880	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	304,093	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	936	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
0			0	416,909	
E - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,558,010	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,039,043	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
0			0	2,597,053	
F - HEP C CLINIC					
1.00	CLINIC	90.00	4,926	2,559	1.00
0			4,926	2,559	

	Increases				
	Cost Center 2.00	Line # 3.00	Salary 4.00	Other 5.00	
G - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,502,954	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	674	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
0			0	2,503,628	
H - RECRUITMENT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8,500	0	1.00
0			8,500	0	
I - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	50,556	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,400	2.00
0			0	56,956	
J - PROPERTY TAX					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,236	1.00
0			0	10,236	
K - IMPLANTIBLES					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,719	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,720	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,243,602	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
0			0	1,256,041	
M - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	408,250	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	169,002	2.00
0			0	577,252	
500.00	Grand Total: Increases		866,740	11,316,568	500.00

		Decreases			Ref.	
Cost Center	Line #	Salary	Other	10.00	10.00	
6.00	7.00	8.00	9.00			
A - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	254,108	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	166,014	0	2.00
3.00	INTENSIVE CARE UNIT	31.00	0	44,827	0	3.00
4.00	SUBPROVIDER - IPF	40.00	0	15,196	0	4.00
5.00	NURSERY	43.00	0	3,699	0	5.00
6.00	OPERATING ROOM	50.00	0	344,487	0	6.00
7.00	RECOVERY ROOM	51.00	0	185	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	40,307	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	570	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,228	0	10.00
11.00	RADIOISOTOPE	56.00	0	28,831	0	11.00
12.00	CT SCAN	57.00	0	54,762	0	12.00
13.00	MRI	58.00	0	637	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	610,948	0	14.00
15.00	LABORATORY	60.00	0	399,672	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	69,209	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	376	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	5,266	0	18.00
19.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	65,192	0	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	34	0	20.00
21.00	WOUND CARE	76.01	0	449	0	21.00
22.00	CLINIC	90.00	0	12,608	0	22.00
23.00	EMERGENCY	91.00	0	327,992	0	23.00
0			0	2,457,597		
B - CAFETERIA						
1.00	DIETARY	10.00	0	1,251,088	0	1.00
0			0	1,251,088		
C - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	853,314	0	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	187,249	0	2.00
3.00		0.00	0	0	0	3.00
0			853,314	187,249		
D - RENT AND LEASES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120	10	1.00
2.00	COMMUNICATIONS	5.01	0	5,101	10	2.00
3.00	ADMITTING	5.04	0	20	0	3.00
4.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1,587	0	4.00
5.00	OPERATION OF PLANT	7.00	0	540	0	5.00
6.00	HOUSEKEEPING	9.00	0	1,660	0	6.00
7.00	DIETARY	10.00	0	180	0	7.00
8.00	NURSING ADMINISTRATION	13.00	0	660	0	8.00
9.00	PHARMACY	15.00	0	154,031	0	9.00
10.00	SOCIAL SERVICE	17.00	0	20	0	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	9,650	0	11.00
12.00	INTENSIVE CARE UNIT	31.00	0	1,396	0	12.00
13.00	SUBPROVIDER - IPF	40.00	0	480	0	13.00
14.00	OPERATING ROOM	50.00	0	5,127	0	14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	7,016	0	15.00
16.00	ANESTHESIOLOGY	53.00	0	20	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	104	0	17.00
18.00	MRI	58.00	0	120	0	18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	2,263	0	19.00
20.00	LABORATORY	60.00	0	91,955	0	20.00
21.00	RESPIRATORY THERAPY	65.00	0	16,430	0	21.00
22.00	PHYSICAL THERAPY	66.00	0	113,063	0	22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	90	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	0	420	0	24.00
25.00	CLINIC	90.00	0	4,586	0	25.00
26.00	EMERGENCY	91.00	0	270	0	26.00
0			0	416,909		
E - DEPRECIATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	26,871	9	1.00
2.00	DIETARY	10.00	0	704	9	2.00
3.00	SUBPROVIDER - IPF	40.00	0	1,115	0	3.00
4.00	OPERATING ROOM	50.00	0	7,320	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,119	0	5.00
6.00	INTEREST EXPENSE	113.00	0	2,558,924	0	6.00
0			0	2,597,053		

		Decreases				
	Cost Center	Line #	Salary	Other	wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
F - HEP C CLINIC						
1.00	WOUND CARE	76.01	4,926	2,559	0	1.00
	0		4,926	2,559		
G - BILLABLE DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,696	0	1.00
2.00	PHARMACY	15.00	0	2,454,250	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,851	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	332	0	4.00
5.00	NURSERY	43.00	0	5	0	5.00
6.00	OPERATING ROOM	50.00	0	3,866	0	6.00
7.00	RECOVERY ROOM	51.00	0	5	0	7.00
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	322	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	7,459	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	218	0	10.00
11.00	RADIOISOTOPE	56.00	0	1,604	0	11.00
12.00	CT SCAN	57.00	0	46	0	12.00
13.00	MRI	58.00	0	4,614	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	170	0	14.00
15.00	LABORATORY	60.00	0	66	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	4,094	0	16.00
17.00	CLINIC	90.00	0	5,827	0	17.00
18.00	EMERGENCY	91.00	0	14,203	0	18.00
	0		0	2,503,628		
H - RECRUITMENT						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,500	0	1.00
	0		0	8,500		
I - INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	56,956	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	56,956		
J - PROPERTY TAX						
1.00	INTEREST EXPENSE	113.00	0	10,236	13	1.00
	0		0	10,236		
K - IMPLANTIBLES						
1.00	ADULTS & PEDIATRICS	30.00	0	2,187	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	759	0	2.00
3.00	SUBPROVIDER - IPF	40.00	0	7	0	3.00
4.00	OPERATING ROOM	50.00	0	551,872	0	4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	33	0	5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	696,997	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	1,842	0	7.00
8.00	ELECTROCARDIOLOGY	69.00	0	94	0	8.00
9.00	EMERGENCY	91.00	0	2,250	0	9.00
	0		0	1,256,041		
M - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	577,252	11	1.00
2.00		0.00	0	0	11	2.00
	0		0	577,252		
500.00	Grand Total: Decreases		858,240	11,325,068		500.00

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - BILLABLE SUPPLIES									
1.00	MEDICAL SUPPLIES	71.00	0	2,430,092	CENTRAL SERVICES & SUPPLY	14.00	0	254,108	1.00
2.00	CHARGED TO PATIENT PHARMACY	15.00	0	27,505	ADULTS & PEDIATRICS	30.00	0	166,014	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	44,827	3.00
4.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	15,196	4.00
5.00		0.00	0	0	NURSERY	43.00	0	3,699	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	344,487	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	185	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	40,307	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	570	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	12,228	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	28,831	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	54,762	12.00
13.00		0.00	0	0	MRI	58.00	0	637	13.00
14.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	610,948	14.00
15.00		0.00	0	0	LABORATORY	60.00	0	399,672	15.00
16.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	69,209	16.00
17.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	376	17.00
18.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	5,266	18.00
19.00		0.00	0	0	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	65,192	19.00
20.00		0.00	0	0	DRUGS CHARGED TO PATIENTS	73.00	0	34	20.00
21.00		0.00	0	0	WOUND CARE	76.01	0	449	21.00
22.00		0.00	0	0	CLINIC	90.00	0	12,608	22.00
23.00		0.00	0	0	EMERGENCY	91.00	0	327,992	23.00
0			0	2,457,597			0	2,457,597	
B - CAFETERIA									
1.00	CAFETERIA	11.00	0	1,251,088	DIETARY	10.00	0	1,251,088	1.00
0			0	1,251,088			0	1,251,088	
C - NURSERY									
1.00	NURSERY	43.00	380,786	156,925	ADULTS & PEDIATRICS	30.00	853,314	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	472,528	0	DELIVERY ROOM & LABOR ROOM	52.00	0	187,249	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	30,324		0.00	0	0	3.00
0			853,314	187,249			853,314	187,249	
D - RENT AND LEASES									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	111,880	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	304,093	COMMUNICATIONS	5.01	0	5,101	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	936	ADMITTING	5.04	0	20	3.00
4.00		0.00	0	0	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	1,587	4.00
5.00		0.00	0	0	OPERATION OF PLANT	7.00	0	540	5.00
6.00		0.00	0	0	HOUSEKEEPING	9.00	0	1,660	6.00
7.00		0.00	0	0	DIETARY	10.00	0	180	7.00
8.00		0.00	0	0	NURSING	13.00	0	660	8.00
9.00		0.00	0	0	ADMINISTRATION	15.00	0	154,031	9.00
10.00		0.00	0	0	PHARMACY	17.00	0	20	10.00
11.00		0.00	0	0	SOCIAL SERVICE	30.00	0	9,650	11.00
12.00		0.00	0	0	ADULTS & PEDIATRICS	31.00	0	1,396	12.00
13.00		0.00	0	0	INTENSIVE CARE UNIT	40.00	0	480	13.00
14.00		0.00	0	0	SUBPROVIDER - IPF	50.00	0	5,127	14.00
15.00		0.00	0	0	OPERATING ROOM	52.00	0	7,016	15.00
16.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	53.00	0	20	16.00
17.00		0.00	0	0	ANESTHESIOLOGY	54.00	0	104	17.00
18.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	58.00	0	120	18.00
19.00		0.00	0	0	MRI	59.00	0	2,263	19.00
20.00		0.00	0	0	CARDIAC CATHETERIZATION	60.00	0	91,955	20.00
21.00		0.00	0	0	LABORATORY	65.00	0	16,430	21.00
22.00		0.00	0	0	RESPIRATORY THERAPY	66.00	0	113,063	22.00
23.00		0.00	0	0	PHYSICAL THERAPY	67.00	0	90	23.00
24.00		0.00	0	0	OCCUPATIONAL THERAPY	69.00	0	420	24.00
25.00		0.00	0	0	ELECTROCARDIOLOGY	90.00	0	4,586	25.00
26.00		0.00	0	0	CLINIC	91.00	0	270	26.00
0			0	416,909	EMERGENCY		0	416,909	

Increases				Decreases					
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
E - DEPRECIATION									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,558,010	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	26,871	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,039,043	DIETARY	10.00	0	704	2.00
3.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	1,115	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	7,320	4.00
5.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	2,119	5.00
6.00		0.00	0	0	INTEREST EXPENSE	113.00	0	2,558,924	6.00
0			0	2,597,053			0	2,597,053	
F - HEP C CLINIC									
1.00	CLINIC	90.00	4,926	2,559	WOUND CARE	76.01	4,926	2,559	1.00
0			4,926	2,559			4,926	2,559	
G - BILLABLE DRUGS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,502,954	CENTRAL SERVICES & SUPPLY	14.00	0	4,696	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	674	PHARMACY	15.00	0	2,454,250	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	1,851	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	332	4.00
5.00		0.00	0	0	NURSERY	43.00	0	5	5.00
6.00		0.00	0	0	OPERATING ROOM	50.00	0	3,866	6.00
7.00		0.00	0	0	RECOVERY ROOM	51.00	0	5	7.00
8.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	322	8.00
9.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	7,459	9.00
10.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	218	10.00
11.00		0.00	0	0	RADIOISOTOPE	56.00	0	1,604	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	46	12.00
13.00		0.00	0	0	MRI	58.00	0	4,614	13.00
14.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	170	14.00
15.00		0.00	0	0	LABORATORY	60.00	0	66	15.00
16.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	4,094	16.00
17.00		0.00	0	0	CLINIC	90.00	0	5,827	17.00
18.00		0.00	0	0	EMERGENCY	91.00	0	14,203	18.00
0			0	2,503,628			0	2,503,628	
H - RECRUITMENT									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8,500	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8,500	1.00
0			8,500	0			0	8,500	
I - INSURANCE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	50,556	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	56,956	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,400		0.00	0	0	2.00
0			0	56,956			0	56,956	
J - PROPERTY TAX									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10,236	INTEREST EXPENSE	113.00	0	10,236	1.00
0			0	10,236			0	10,236	
K - IMPLANTIBLES									
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,719	ADULTS & PEDIATRICS	30.00	0	2,187	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,720	INTENSIVE CARE UNIT	31.00	0	759	2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,243,602	SUBPROVIDER - IPF	40.00	0	7	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	551,872	4.00
5.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	33	5.00
6.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	696,997	6.00
7.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	1,842	7.00
8.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	94	8.00
9.00		0.00	0	0	EMERGENCY	91.00	0	2,250	9.00
0			0	1,256,041			0	1,256,041	
M - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	408,250	INTEREST EXPENSE	113.00	0	577,252	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	169,002		0.00	0	0	2.00
0			0	577,252			0	577,252	
500.00	Grand Total: Increases		866,740	11,316,568	Grand Total: Decreases		858,240	11,325,068	500.00

	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	1,869,112	0	0	0	0	1.00
2.00 Land Improvements	438,536	182,345	0	182,345	0	2.00
3.00 Buildings and Fixtures	35,895,338	69,310	0	69,310	0	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	7,845,911	767,320	0	767,320	0	5.00
6.00 Movable Equipment	17,630,397	0	0	0	388,888	6.00
7.00 HIT designated Assets	0	0	0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	63,679,294	1,018,975	0	1,018,975	388,888	8.00
9.00 Reconciling Items	0	0	0	0	0	9.00
10.00 Total (line 8 minus line 9)	63,679,294	1,018,975	0	1,018,975	388,888	10.00
	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	1,869,112	0				1.00
2.00 Land Improvements	620,881	0				2.00
3.00 Buildings and Fixtures	35,964,648	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	8,613,231	0				5.00
6.00 Movable Equipment	17,241,509	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	64,309,381	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	64,309,381	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2018 9:38 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0292

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	47,067,872	0	47,067,872	0.731897	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,241,509	0	17,241,509	0.268103	0	2.00
3.00	Total (sum of lines 1-2)	64,309,381	0	64,309,381	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,648,665	111,880	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,320,692	304,093	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,969,357	415,973	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	-10,236	50,556	10,236	-13,007	1,798,094	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,400	0	0	1,631,185	2.00
3.00	Total (sum of lines 1-2)	-10,236	56,956	10,236	-13,007	3,429,279	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted				Ref.
			Cost Center	Line #	wkst. A-7	5.00	
			1.00	2.00	3.00	4.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-408,250	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00	
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-169,002	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00	
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00	
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00	
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00	
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00	
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-23,875	COMMUNICATIONS	5.01	0	7.00	
8.00 Television and radio service (chapter 21)	A	-16,341	OPERATION OF PLANT	7.00	0	8.00	
9.00 Parking lot (chapter 21)		0		0.00	0	9.00	
10.00 Provider-based physician adjustment	A-8-2	-205,983			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	383,804			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 employees and others		0		0.00	0	15.00	
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00	
17.00 Sale of drugs to other than patients		0		0.00	0	17.00	
18.00 Sale of medical records and abstracts		0		0.00	0	18.00	
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00	
20.00 Vending machines		0		0.00	0	20.00	
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00	
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00	
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00	
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00	
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00	
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00	
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00	
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00	
29.00 Physicians' assistant		0		0.00	0	29.00	
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00	
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99	
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00	
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00	
33.00 MISC REVENUE	B	-18,127	ADMITTING	5.04	0	33.00	

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted		Line #	wkst. A-7	Ref.
				3.00	4.00			
		1.00	2.00	3.00	4.00	5.00		
33.01	MISC REVENUE	B	-1,123,538	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.01
33.02	MISC REVENUE	B	-546	OPERATION OF PLANT		7.00	0	33.02
33.03	MISC REVENUE	B	-272	HOUSEKEEPING		9.00	0	33.03
33.04	MISC REVENUE	B	-395,713	DIETARY		10.00	0	33.04
33.05	MISC REVENUE	B	-261	CENTRAL SERVICES & SUPPLY		14.00	0	33.05
33.06	MISC REVENUE	B	-329	MEDICAL RECORDS & LIBRARY		16.00	0	33.06
33.07	MISC REVENUE	B	-166	ADULTS & PEDIATRICS		30.00	0	33.07
33.08	MISC REVENUE	B	-2,817	INTENSIVE CARE UNIT		31.00	0	33.08
33.09	MISC REVENUE	B	0	OPERATING ROOM		50.00	0	33.09
33.10	MISC REVENUE	B	47	DELIVERY ROOM & LABOR ROOM		52.00	0	33.10
33.11	MISC REVENUE	B	-1,395	RADIOLOGY-DIAGNOSTIC		54.00	0	33.11
33.12	MISC REVENUE	B	-766	LABORATORY		60.00	0	33.12
33.13	MISC REVENUE	B	0	PHYSICAL THERAPY		66.00	0	33.13
33.14	MISC REVENUE	B	0	ELECTROCARDIOLOGY		69.00	0	33.14
33.15	MISC REVENUE	B	0	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0	33.15
33.17	MISC REVENUE	B	-170	DRUGS CHARGED TO PATIENTS		73.00	0	33.17
33.18	MISC REVENUE	B	-300	RENAL DIALYSIS		74.00	0	33.18
33.19	MISC REVENUE	B	-37,855	CLINIC		90.00	0	33.19
33.20	MISC REVENUE	B	-10,000	EMERGENCY		91.00	0	33.20
33.21	MISC REVENUE	B	-13,007	CAP REL COSTS-BLDG & FIXT		1.00	14	33.21
33.22	LEGAL	A	-57,500	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.22
33.23	LEGAL	A	-525	ADULTS & PEDIATRICS		30.00	0	33.23
33.24	LOBBYING	A	-29,588	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.24
33.25	LOBBYING	A	-74	LABORATORY		60.00	0	33.25
33.26	NON ALLOW PHYSICIAN	A	-379,735	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	33.26
33.27	NON ALLOW PHYSICIAN	A	-4,000	SOCIAL SERVICE		17.00	0	33.27
33.28	NON ALLOW PHYSICIAN	A	-490,650	DELIVERY ROOM & LABOR ROOM		52.00	0	33.28
33.29	NON ALLOW PHYSICIAN	A	-118,950	RADIOLOGY-DIAGNOSTIC		54.00	0	33.29
33.30	NON ALLOW PHYSICIAN	A	-75,350	CARDIAC CATHETERIZATION		59.00	0	33.30
33.31	NON ALLOW PHYSICIAN	A	-42,275	ELECTROCARDIOLOGY		69.00	0	33.31
33.32	NON ALLOW PHYSICIAN	A	-1,307,556	EMERGENCY		91.00	0	33.32
33.33	HOSPICE	A	-444	RADIOLOGY-DIAGNOSTIC		54.00	0	33.33
33.34	HOSPICE	A	-634	LABORATORY		60.00	0	33.34
33.35	HOSPICE	A	-3,950	RESPIRATORY THERAPY		65.00	0	33.35
33.36	HOSPICE	A	-41	ELECTROCARDIOLOGY		69.00	0	33.36
33.37	HOSPICE	A	-3	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0	33.37
33.38	HOSPICE	A	-6,661	DRUGS CHARGED TO PATIENTS		73.00	0	33.38
33.39	HOSPICE	A	-444	EMERGENCY		91.00	0	33.39
33.40	HOSPICE	A	-29,916	ADULTS & PEDIATRICS		30.00	0	33.40
33.41	HOSPICE	A	-7,221	INTENSIVE CARE UNIT		31.00	0	33.41
33.43	PROPERTY TAXES	A	-10,236	CAP REL COSTS-BLDG & FIXT		1.00	11	33.43
35.00	STATE ASSESSMENT	A	-4,886,628	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	35.00
37.00	NON ALLOW COLLECTION FEE	A	-2,927	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	37.00
38.00	MALPRACTICE	A	-736,147	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	38.00
39.00	ADVERTISING	A	-38,430	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	39.00
41.00	ADVERTISING	A	-2,825	NURSING ADMINISTRATION		13.00	0	41.00
42.00	ADVERTISING	A	-750	CENTRAL SERVICES & SUPPLY		14.00	0	42.00
43.00	ADVERTISING	A	-130	PHYSICAL THERAPY		66.00	0	43.00
44.00	ADVERTISING	A	-573	EMERGENCY		91.00	0	44.00
45.00	ENTERTAINMENT	A	-819	ADMITTING		5.04	0	45.00
46.00	ENTERTAINMENT	A	-1,096	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	46.00
46.01	ENTERTAINMENT	A	-37	OPERATION OF PLANT		7.00	0	46.01
46.02	ENTERTAINMENT	A	-463	NURSING ADMINISTRATION		13.00	0	46.02
46.03	ENTERTAINMENT	A	-271	ADULTS & PEDIATRICS		30.00	0	46.03
46.04	ENTERTAINMENT	A	-203	RADIOLOGY-DIAGNOSTIC		54.00	0	46.04
46.05	ENTERTAINMENT	A	-309	CARDIAC CATHETERIZATION		59.00	0	46.05
46.06	ENTERTAINMENT	A	-62	EMERGENCY		91.00	0	46.06
46.07	CORPORATE SPONSORSHIP	A	-1,000	OTHER ADMINISTRATIVE AND GENERAL		5.06	0	46.07

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted			wkst. A-7	Ref.
				Cost Center	Line #			
		1.00	2.00	3.00	4.00	5.00		
46.08	NON ALLOW AMBULANCE	A	-329	INTENSIVE CARE UNIT	31.00		0	46.08
46.09	NON ALLOW AMBULANCE	A	-33	OPERATING ROOM	50.00		0	46.09
46.10	NON ALLOW AMBULANCE	A	-40	DELIVERY ROOM & LABOR ROOM	52.00		0	46.10
46.11	NON ALLOW AMBULANCE	A	-8,103	EMERGENCY	91.00		0	46.11
46.12	GAIN/LOSS	A	-776	INTEREST EXPENSE	113.00		0	46.12
46.13	NON ALLOW HOSPITALIST	A	-123,336	EMERGENCY	91.00		0	46.13
46.14	NON ALLOW INTEREST	A	-36,304	INTEREST EXPENSE	113.00		0	46.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-10,452,206					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: 14-0292

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

worksheet A-8-1

Date/Time Prepared: 5/29/2018 9:38 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	90,655	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	281,649	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	127,130	44,418
3.01	5.06	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE	4,562,550	4,952,410
3.02	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	8,330	0
4.00	113.00	INTEREST EXPENSE	HOME OFFICE	613,555	303,237
4.01	0.00		HOME OFFICE	0	0
4.02	0.00		HOME OFFICE	0	0
4.03	0.00		HOME OFFICE	0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			5,683,869	5,300,065

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

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

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

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

6.00	B	AHS CORPORATE	100.00	AHS CORPORATE	0.00	6.00
7.00	B	SHARED SERVICE	0.00	SHARED SERVICE	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.

	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	90,655	9	1.00
2.00	281,649	9	2.00
3.00	82,712	0	3.00
3.01	-389,860	0	3.01
3.02	8,330	0	3.02
4.00	310,318	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
5.00	383,804		5.00

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

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

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

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

6.00	MANAGEMENT SVCS	6.00
7.00	FINANCIAL SVCS	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.

	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	200.00
1.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	169,978	169,978	0	0	0	0	0	0	1.00
2.00	91.00	AGGREGATE-EMERGENCY	10,005	10,005	0	0	0	0	0	0	2.00
3.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	26,000	26,000	0	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	0	0	0	10.00
200.00			205,983	205,983	0	0	0	0	0	0	200.00
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	200.00	
1.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	1.00
2.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	0	0	0	2.00
3.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	0	0	0	10.00
200.00			0	0	0	0	0	0	0	0	200.00
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	200.00	
1.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	169,978	0	0	0	0	1.00
2.00	91.00	AGGREGATE-EMERGENCY	0	0	0	10,005	0	0	0	0	2.00
3.00	5.06	AGGREGATE-OTHER ADMINISTRATIVE AND G	0	0	0	26,000	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	0	0	0	10.00
200.00			0	0	0	205,983	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,798,094	1,798,094			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,631,185		1,631,185		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,640,681	10,412	9,445	4,660,538	4.00
5.01 01160	COMMUNICATIONS	50,370	0	0	0	5.01
5.04 00570	ADMITTING	870,629	6,026	5,467	97,378	5.04
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	17,934,009	41,583	37,723	302,586	5.06
7.00 00700	OPERATION OF PLANT	2,981,688	533,534	484,009	119,493	7.00
9.00 00900	HOUSEKEEPING	1,772,669	13,796	12,515	0	9.00
10.00 01000	DIETARY	451,456	48,129	43,662	0	10.00
11.00 01100	CAFETERIA	1,251,088	27,969	25,373	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,446,869	6,534	5,927	149,179	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	312,881	55,535	50,380	30,712	14.00
15.00 01500	PHARMACY	1,664,880	19,405	17,604	192,198	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	284,215	12,585	11,417	34,608	16.00
17.00 01700	SOCIAL SERVICE	712,049	5,596	5,077	67,525	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,828,948	397,190	360,321	1,123,753	30.00
31.00 03100	INTENSIVE CARE UNIT	2,753,402	39,032	35,409	278,446	31.00
40.00 04000	SUBPROVIDER - IPF	2,434,486	62,277	56,496	287,080	40.00
43.00 04300	NURSERY	539,461	0	0	49,624	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,934,009	115,339	104,632	179,060	50.00
51.00 05100	RECOVERY ROOM	253,998	7,939	7,202	30,804	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,038,736	0	0	144,082	52.00
53.00 05300	ANESTHESIOLOGY	94,323	2,160	1,960	6,418	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,081,662	49,509	44,913	119,721	54.00
56.00 05600	RADIOISOTOPE	166,898	13,523	12,267	19,815	56.00
57.00 05700	CT SCAN	463,281	0	0	55,792	57.00
58.00 05800	MRI	159,152	17,011	15,432	19,375	58.00
59.00 05900	CARDIAC CATHETERIZATION	952,595	20,759	18,832	93,430	59.00
60.00 06000	LABORATORY	2,206,591	32,511	29,493	179,175	60.00
65.00 06500	RESPIRATORY THERAPY	857,654	4,568	4,144	95,133	65.00
66.00 06600	PHYSICAL THERAPY	1,114,263	16,581	15,042	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	175,375	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	46,450	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	292,626	26,798	24,310	44,602	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	28,500	0	0	3,491	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,472,431	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,510,637	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,496,124	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	335,056	0	0	0	74.00
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01 03060	WOUND CARE	91,480	9,514	8,631	29	76.01
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	399,394	20,902	18,962	51,566	90.00
91.00 09100	EMERGENCY	2,793,498	101,491	92,070	307,693	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	74,323,793	1,718,208	1,558,715	4,082,768	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,377	0	0	5,902	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,067,080	13,015	11,807	0	192.00
192.03 19203	OP PHARMACY	842,251	1,965	1,783	21,430	192.03
194.00 07950	FOUNDATION	203,613	2,330	2,113	21,696	194.00
194.01 07951	MARKETING	3,286	3,098	2,810	0	194.01
194.03 07953	THERAPEUTIC DAY SCHOOL	5,383,440	59,478	53,957	528,742	194.03
200.00	Cross Foot Adjustments		0	0	0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	82,878,840	1,798,094	1,631,185	4,660,538	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		ADMITTING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
		5.04	5A.04	5.06	7.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570	979,500					5.04
5.06	00560	0	18,352,339	18,352,339			5.06
7.00	00700	0	4,118,724	1,171,431	5,290,155		7.00
9.00	00900	0	1,798,980	511,659	60,489	2,371,128	9.00
10.00	01000	0	543,247	154,508	211,026	95,679	10.00
11.00	01100	0	1,304,430	371,001	122,633	55,602	11.00
13.00	01300	0	1,608,509	457,486	28,647	12,988	13.00
14.00	01400	0	449,508	127,847	243,496	110,401	14.00
15.00	01500	0	1,894,087	538,709	85,084	38,577	15.00
16.00	01600	0	342,825	97,505	55,182	25,019	16.00
17.00	01700	0	790,247	224,759	24,538	11,125	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	127,627	11,849,238	3,370,083	1,741,509	789,601	30.00
31.00	03100	21,081	3,128,344	889,751	171,138	77,594	31.00
40.00	04000	25,290	2,867,188	815,474	273,056	123,803	40.00
43.00	04300	2,291	591,376	168,197	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	47,896	2,380,936	677,176	505,710	229,289	50.00
51.00	05100	7,483	307,426	87,437	34,810	15,783	51.00
52.00	05200	5,660	1,188,478	338,022	0	0	52.00
53.00	05300	14,161	119,022	33,852	9,473	4,295	53.00
54.00	05400	64,738	1,360,543	386,960	217,075	98,422	54.00
56.00	05600	11,171	223,674	63,616	59,291	26,882	56.00
57.00	05700	102,710	621,783	176,845	0	0	57.00
58.00	05800	17,358	228,328	64,940	74,584	33,816	58.00
59.00	05900	20,246	1,105,862	314,525	91,019	41,268	59.00
60.00	06000	130,112	2,577,882	733,191	142,548	64,631	60.00
65.00	06500	26,331	987,830	280,955	20,030	9,082	65.00
66.00	06600	13,726	1,159,612	329,812	72,701	32,963	66.00
66.00	06600	1,601	176,976	50,335	0	0	67.00
67.00	06700	1,004	47,454	13,497	0	0	68.00
68.00	06800	33,375	421,711	119,941	117,497	53,273	69.00
69.00	06900	1,019	33,010	9,389	0	0	70.00
70.00	07000	12,511	2,484,942	706,757	0	0	71.00
71.00	07100	21,947	1,532,584	435,891	0	0	72.00
72.00	07200	87,649	2,583,773	734,866	0	0	73.00
73.00	07300	2,397	337,453	95,977	0	0	74.00
74.00	07400	0	0	0	0	0	76.00
76.00	03050	0	0	0	41,715	18,913	76.01
76.01	03060	5	109,659	31,189	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	8,453	499,277	142,002	91,646	41,552	90.00
91.00	09100	171,658	3,466,410	985,902	444,993	201,760	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		979,500	73,593,667	15,711,487	4,939,890	2,212,318	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	61,279	17,429	0	0	190.00
192.00	19200	0	2,091,902	594,970	57,065	25,873	192.00
192.03	19203	0	867,429	246,711	8,617	3,907	192.03
194.00	07950	0	229,752	65,345	10,215	4,631	194.00
194.01	07951	0	9,194	2,615	13,581	6,158	194.01
194.03	07953	0	6,025,617	1,713,782	260,787	118,241	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		979,500	82,878,840	18,352,339	5,290,155	2,371,128	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	1,004,460					10.00
11.00	01100		1,853,666				11.00
13.00	01300		51,391	2,159,021			13.00
14.00	01400		28,605	41,914	1,001,771		14.00
15.00	01500		68,440	100,285	1,270	2,726,452	15.00
16.00	01600		21,527	31,544	0	0	16.00
17.00	01700		20,440	29,950	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	764,833	728,475	1,067,420	24,364	0	30.00
31.00	03100	87,253	138,671	203,192	17,076	0	31.00
40.00	04000	152,374	156,577	229,430	2,923	0	40.00
43.00	04300	0	0	0	236	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	68,782	100,785	387,956	914	50.00
51.00	05100	0	19,989	29,290	75	0	51.00
52.00	05200	0	18,900	27,693	6,852	0	52.00
53.00	05300	0	3,180	4,659	5,394	8,005	53.00
54.00	05400	0	52,580	0	4,621	232	54.00
56.00	05600	0	12,396	0	6,017	1,721	56.00
57.00	05700	0	32,739	0	994	49	57.00
58.00	05800	0	11,751	0	11	4,952	58.00
59.00	05900	0	41,205	0	360,544	0	59.00
60.00	06000	0	95,543	0	0	0	60.00
65.00	06500	0	53,114	0	7,515	0	65.00
66.00	06600	0	0	0	202	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	21,089	0	450	4,404	69.00
70.00	07000	0	1,874	0	0	0	70.00
71.00	07100	0	0	0	13,208	0	71.00
72.00	07200	0	0	0	130,575	0	72.00
73.00	07300	0	0	0	0	2,686,145	73.00
74.00	07400	0	0	0	0	0	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	0	204	0	366	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	16,412	24,049	1,250	6,253	90.00
91.00	09100	0	183,452	268,810	29,872	13,777	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,004,460	1,847,336	2,159,021	1,001,771	2,726,452	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	1,889	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	4,441	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		1,004,460	1,853,666	2,159,021	1,001,771	2,726,452	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0292

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

Worksheet B Part I Date/Time Prepared: 5/29/2018 9:38 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	573,602				16.00
17.00	01700	SOCIAL SERVICE	0	1,101,059			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	74,729	820,590	21,230,842	0	21,230,842
31.00	03100	INTENSIVE CARE UNIT	12,343	93,860	4,819,222	0	4,819,222
40.00	04000	SUBPROVIDER - IPF	14,808	163,903	4,799,536	0	4,799,536
43.00	04300	NURSERY	1,341	22,706	783,856	0	783,856
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	28,044	0	4,379,592	0	4,379,592
51.00	05100	RECOVERY ROOM	4,381	0	499,191	0	499,191
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,314	0	1,583,259	0	1,583,259
53.00	05300	ANESTHESIOLOGY	8,292	0	196,172	0	196,172
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,906	0	2,158,339	0	2,158,339
56.00	05600	RADIOISOTOPE	6,541	0	400,138	0	400,138
57.00	05700	CT SCAN	60,140	0	892,550	0	892,550
58.00	05800	MRI	10,163	0	428,545	0	428,545
59.00	05900	CARDIAC CATHETERIZATION	11,855	0	1,966,278	0	1,966,278
60.00	06000	LABORATORY	76,184	0	3,689,979	0	3,689,979
65.00	06500	RESPIRATORY THERAPY	15,417	0	1,373,943	0	1,373,943
66.00	06600	PHYSICAL THERAPY	8,037	0	1,603,327	0	1,603,327
67.00	06700	OCCUPATIONAL THERAPY	937	0	228,248	0	228,248
68.00	06800	SPEECH PATHOLOGY	588	0	61,539	0	61,539
69.00	06900	ELECTROCARDIOLOGY	19,542	0	757,907	0	757,907
70.00	07000	ELECTROENCEPHALOGRAPHY	596	0	44,869	0	44,869
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,325	0	3,212,232	0	3,212,232
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,850	0	2,111,900	0	2,111,900
73.00	07300	DRUGS CHARGED TO PATIENTS	51,321	0	6,056,105	0	6,056,105
74.00	07400	RENAL DIALYSIS	1,404	0	434,834	0	434,834
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	3	0	202,049	0	202,049
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	4,949	0	827,390	0	827,390
91.00	09100	EMERGENCY	100,592	0	5,695,568	0	5,695,568
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE				0	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	573,602	1,101,059	70,437,410	0	70,437,410
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	80,597	0	80,597
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,769,810	0	2,769,810
192.03	19203	OP PHARMACY	0	0	1,131,105	0	1,131,105
194.00	07950	FOUNDATION	0	0	309,943	0	309,943
194.01	07951	MARKETING	0	0	31,548	0	31,548
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	8,118,427	0	8,118,427
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	573,602	1,101,059	82,878,840	0	82,878,840

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.01	COMMUNICATIONS	2	NUMBER OF PHONES	5.01
5.04	ADMITTING	C	GROSS CHAR GES	5.04
5.06	OTHER ADMINISTRATIVE AND GENERAL	-1	ACCUM. COST	5.06
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	HOURS WORKED	11.00
13.00	NURSING ADMINISTRATION	5	DIRECT NRSING	13.00
14.00	CENTRAL SERVICES & SUPPLY	6	COSTED REQUIS.	14.00
15.00	PHARMACY	7	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00
17.00	SOCIAL SERVICE	8	TOTAL PATI ENT DAYS	17.00

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,412	9,445	19,857	19,857
5.01 01160	COMMUNICATIONS	0	0	0	0	0
5.04 00570	ADMITTING	0	6,026	5,467	11,493	415
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	0	41,583	37,723	79,306	1,289
7.00 00700	OPERATION OF PLANT	0	533,534	484,009	1,017,543	509
9.00 00900	HOUSEKEEPING	0	13,796	12,515	26,311	0
10.00 01000	DIETARY	0	48,129	43,662	91,791	0
11.00 01100	CAFETERIA	0	27,969	25,373	53,342	0
13.00 01300	NURSING ADMINISTRATION	0	6,534	5,927	12,461	635
14.00 01400	CENTRAL SERVICES & SUPPLY	0	55,535	50,380	105,915	131
15.00 01500	PHARMACY	0	19,405	17,604	37,009	819
16.00 01600	MEDICAL RECORDS & LIBRARY	0	12,585	11,417	24,002	147
17.00 01700	SOCIAL SERVICE	0	5,596	5,077	10,673	288
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	397,190	360,321	757,511	4,793
31.00 03100	INTENSIVE CARE UNIT	0	39,032	35,409	74,441	1,186
40.00 04000	SUBPROVIDER - IPF	0	62,277	56,496	118,773	1,223
43.00 04300	NURSERY	0	0	0	0	211
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	115,339	104,632	219,971	763
51.00 05100	RECOVERY ROOM	0	7,939	7,202	15,141	131
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	614
53.00 05300	ANESTHESIOLOGY	0	2,160	1,960	4,120	27
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	49,509	44,913	94,422	510
56.00 05600	RADIOISOTOPE	0	13,523	12,267	25,790	84
57.00 05700	CT SCAN	0	0	0	0	238
58.00 05800	MRI	0	17,011	15,432	32,443	83
59.00 05900	CARDIAC CATHETERIZATION	0	20,759	18,832	39,591	398
60.00 06000	LABORATORY	0	32,511	29,493	62,004	763
65.00 06500	RESPIRATORY THERAPY	0	4,568	4,144	8,712	405
66.00 06600	PHYSICAL THERAPY	0	16,581	15,042	31,623	0
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	0
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	0	26,798	24,310	51,108	190
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	15
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03060	WOUND CARE	0	9,514	8,631	18,145	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	20,902	18,962	39,864	220
91.00 09100	EMERGENCY	0	101,491	92,070	193,561	1,310
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1,718,208	1,558,715	3,276,923	17,397
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	25
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	13,015	11,807	24,822	0
192.03 19203	OP PHARMACY	0	1,965	1,783	3,748	91
194.00 07950	FOUNDATION	0	2,330	2,113	4,443	92
194.01 07951	MARKETING	0	3,098	2,810	5,908	0
194.03 07953	THERAPEUTIC DAY SCHOOL	0	59,478	53,957	113,435	2,252
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1,798,094	1,631,185	3,429,279	19,857

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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

Worksheet B
Part II
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		COMMUNICATIONS	ADMITTING	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	HOUSEKEEPING	
		5.01	5.04	5.06	7.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS	0				5.01
5.04	00570	ADMITTING	0	11,908			5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	0	0	80,595		5.06
7.00	00700	OPERATION OF PLANT	0	0	5,144	1,023,196	7.00
9.00	00900	HOUSEKEEPING	0	0	2,247	11,699	40,257
10.00	01000	DIETARY	0	0	679	40,816	1,624
10.00	01000	DIETARY	0	0	679	40,816	1,624
11.00	01100	CAFETERIA	0	0	1,629	23,719	944
13.00	01300	NURSING ADMINISTRATION	0	0	2,009	5,541	221
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	561	47,096	1,874
15.00	01500	PHARMACY	0	0	2,366	16,457	655
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	428	10,673	425
17.00	01700	SOCIAL SERVICE	0	0	987	4,746	189
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,562	14,802	336,833	13,408
31.00	03100	INTENSIVE CARE UNIT	0	258	3,907	33,101	1,317
40.00	04000	SUBPROVIDER - IPF	0	309	3,581	52,813	2,102
43.00	04300	NURSERY	0	28	739	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	586	2,974	97,812	3,893
51.00	05100	RECOVERY ROOM	0	92	384	6,733	268
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	69	1,484	0	0
53.00	05300	ANESTHESIOLOGY	0	173	149	1,832	73
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	792	1,699	41,986	1,671
56.00	05600	RADIOISOTOPE	0	137	279	11,468	456
57.00	05700	CT SCAN	0	1,257	777	0	0
58.00	05800	MRI	0	212	285	14,426	574
59.00	05900	CARDIAC CATHETERIZATION	0	248	1,381	17,604	701
60.00	06000	LABORATORY	0	1,592	3,220	27,571	1,097
65.00	06500	RESPIRATORY THERAPY	0	322	1,234	3,874	154
66.00	06600	PHYSICAL THERAPY	0	168	1,448	14,061	560
67.00	06700	OCCUPATIONAL THERAPY	0	20	221	0	0
68.00	06800	SPEECH PATHOLOGY	0	12	59	0	0
69.00	06900	ELECTROCARDIOLOGY	0	408	527	22,726	904
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12	41	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	153	3,104	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	269	1,914	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,073	3,227	0	0
74.00	07400	RENAL DIALYSIS	0	29	421	0	0
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	0	0	137	8,068	321
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	103	624	17,726	705
91.00	09100	EMERGENCY	0	2,024	4,330	86,068	3,425
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,908	68,998	955,449	37,561
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	77	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	2,613	11,037	439
192.03	19203	OP PHARMACY	0	0	1,083	1,667	66
194.00	07950	FOUNDATION	0	0	287	1,976	79
194.01	07951	MARKETING	0	0	11	2,627	105
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	7,526	50,440	2,007
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	11,908	80,595	1,023,196	40,257

Health Financial Systems

ADVENTIST GLENOAKS HOSPITAL

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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

Worksheet B Part II Date/Time Prepared: 5/29/2018 9:38 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000	134,910					10.00
11.00	01100	0	79,634				11.00
13.00	01300	0	2,208	23,075			13.00
14.00	01400	0	1,229	448	157,254		14.00
15.00	01500	0	2,940	1,072	199	61,517	15.00
16.00	01600	0	925	337	0	0	16.00
17.00	01700	0	878	320	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	102,725	31,294	11,408	3,824	0	30.00
31.00	03100	11,719	5,957	2,172	2,680	0	31.00
40.00	04000	20,466	6,727	2,452	459	0	40.00
43.00	04300	0	0	0	37	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,955	1,077	60,901	21	50.00
51.00	05100	0	859	313	12	0	51.00
52.00	05200	0	812	296	1,076	0	52.00
53.00	05300	0	137	50	847	181	53.00
54.00	05400	0	2,259	0	725	5	54.00
56.00	05600	0	533	0	945	39	56.00
57.00	05700	0	1,406	0	156	1	57.00
58.00	05800	0	505	0	2	112	58.00
59.00	05900	0	1,770	0	56,596	0	59.00
60.00	06000	0	4,105	0	0	0	60.00
65.00	06500	0	2,282	0	1,180	0	65.00
66.00	06600	0	0	0	32	0	66.00
66.00	06600	0	0	0	0	0	67.00
67.00	06700	0	0	0	0	0	68.00
68.00	06800	0	0	0	71	99	68.00
69.00	06900	0	80	0	0	0	70.00
70.00	07000	0	0	0	2,073	0	71.00
71.00	07100	0	0	0	20,497	0	72.00
72.00	07200	0	0	0	0	60,607	73.00
73.00	07300	0	0	0	0	0	74.00
74.00	07400	0	0	0	0	0	76.00
76.00	03050	0	0	0	57	0	76.00
76.01	03060	0	9	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	705	257	196	141	90.00
91.00	09100	0	7,881	2,873	4,689	311	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		134,910	79,362	23,075	157,254	61,517	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	81	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	0	191	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		134,910	79,634	23,075	157,254	61,517	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0292

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

worksheet B
Part II
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL					5.06
7.00	00700	OPERATION OF PLANT					7.00
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	36,937				16.00
17.00	01700	SOCIAL SERVICE	0	18,081			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,821	13,475	1,296,456	0	1,296,456
31.00	03100	INTENSIVE CARE UNIT	796	1,541	139,075	0	139,075
40.00	04000	SUBPROVIDER - IPF	955	2,692	212,552	0	212,552
43.00	04300	NURSERY	87	373	1,475	0	1,475
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,809	0	392,762	0	392,762
51.00	05100	RECOVERY ROOM	283	0	24,216	0	24,216
52.00	05200	DELIVERY ROOM & LABOR ROOM	214	0	4,565	0	4,565
53.00	05300	ANESTHESIOLOGY	535	0	8,124	0	8,124
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,446	0	146,515	0	146,515
56.00	05600	RADIOISOTOPE	422	0	40,153	0	40,153
57.00	05700	CT SCAN	3,880	0	7,715	0	7,715
58.00	05800	MRI	656	0	49,298	0	49,298
59.00	05900	CARDIAC CATHETERIZATION	765	0	119,054	0	119,054
60.00	06000	LABORATORY	4,915	0	105,267	0	105,267
65.00	06500	RESPIRATORY THERAPY	995	0	19,158	0	19,158
66.00	06600	PHYSICAL THERAPY	519	0	48,411	0	48,411
67.00	06700	OCCUPATIONAL THERAPY	60	0	301	0	301
68.00	06800	SPEECH PATHOLOGY	38	0	109	0	109
69.00	06900	ELECTROCARDIOLOGY	1,261	0	78,200	0	78,200
70.00	07000	ELECTROENCEPHALOGRAPHY	38	0	186	0	186
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	473	0	5,803	0	5,803
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	829	0	23,509	0	23,509
73.00	07300	DRUGS CHARGED TO PATIENTS	3,311	0	68,218	0	68,218
74.00	07400	RENAL DIALYSIS	91	0	541	0	541
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01	03060	WOUND CARE	0	0	26,737	0	26,737
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	319	0	60,860	0	60,860
91.00	09100	EMERGENCY	6,419	0	312,891	0	312,891
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	36,937	18,081	3,192,151	0	3,192,151
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	183	0	183
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	38,911	0	38,911
192.03	19203	OP PHARMACY	0	0	6,846	0	6,846
194.00	07950	FOUNDATION	0	0	6,877	0	6,877
194.01	07951	MARKETING	0	0	8,651	0	8,651
194.03	07953	THERAPEUTIC DAY SCHOOL	0	0	175,660	0	175,660
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	36,937	18,081	3,429,279	0	3,429,279

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQ. FEET)	MVBLE EQUIP (SQ. FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	138,156				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		138,156			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	800	800	35,762,080		4.00
5.01 01160	COMMUNICATIONS	0	0	0	517	5.01
5.04 00570	ADMITTING	463	463	747,220	0	260,599,994
5.06 00560	OTHER ADMINISTRATIVE AND GENERAL	3,195	3,195	2,321,854	374	0
7.00 00700	OPERATION OF PLANT	40,994	40,994	916,910	0	0
9.00 00900	HOUSEKEEPING	1,060	1,060	0	0	0
10.00 01000	DIETARY	3,698	3,698	0	0	0
11.00 01100	CAFETERIA	2,149	2,149	0	0	0
13.00 01300	NURSING ADMINISTRATION	502	502	1,144,703	0	0
14.00 01400	CENTRAL SERVICES & SUPPLY	4,267	4,267	235,668	0	0
15.00 01500	PHARMACY	1,491	1,491	1,474,801	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	967	967	265,560	0	0
17.00 01700	SOCIAL SERVICE	430	430	518,147	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	30,518	30,518	8,623,034	117	33,952,367
31.00 03100	INTENSIVE CARE UNIT	2,999	2,999	2,136,616	10	5,608,128
40.00 04000	SUBPROVIDER - IPF	4,785	4,785	2,202,871	16	6,727,865
43.00 04300	NURSERY	0	0	380,786	0	609,399
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8,862	8,862	1,373,992	0	12,741,560
51.00 05100	RECOVERY ROOM	610	610	236,368	0	1,990,582
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	1,105,596	0	1,505,746
53.00 05300	ANESTHESIOLOGY	166	166	49,250	0	3,767,355
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,804	3,804	918,661	0	17,222,106
56.00 05600	RADIOISOTOPE	1,039	1,039	152,050	0	2,971,928
57.00 05700	CT SCAN	0	0	428,112	0	27,323,816
58.00 05800	MRI	1,307	1,307	148,670	0	4,617,649
59.00 05900	CARDIAC CATHETERIZATION	1,595	1,595	716,923	0	5,386,054
60.00 06000	LABORATORY	2,498	2,498	1,374,876	0	34,613,458
65.00 06500	RESPIRATORY THERAPY	351	351	729,991	0	7,004,685
66.00 06600	PHYSICAL THERAPY	1,274	1,274	0	0	3,651,507
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	425,884
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	266,979
69.00 06900	ELECTROCARDIOLOGY	2,059	2,059	342,251	0	8,878,581
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	26,791	0	270,977
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,328,237
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,838,428
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	23,317,040
74.00 07400	RENAL DIALYSIS	0	0	0	0	637,673
76.00 03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0
76.01 03060	WOUND CARE	731	731	220	0	1,442
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,606	1,606	395,682	0	2,248,619
91.00 09100	EMERGENCY	7,798	7,798	2,361,036	0	45,691,929
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	132,018	132,018	31,328,639	517	260,599,994
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	45,292	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,000	1,000	0	0	0
192.03 19203	OP PHARMACY	151	151	164,441	0	0
194.00 07950	FOUNDATION	179	179	166,483	0	0
194.01 07951	MARKETING	238	238	0	0	0
194.03 07953	THERAPEUTIC DAY SCHOOL	4,570	4,570	4,057,225	0	0
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)	1,798,094	1,631,185	4,660,538	50,370	979,500
203.00	Unit cost multiplier (wkst. B, Part I)	13.014954	11.806834	0.130321	97.427466	0.003759
204.00	Cost to be allocated (per wkst. B, Part II)			19,857	0	11,908
205.00	Unit cost multiplier (wkst. B, Part II)			0.000555	0.000000	0.000046
206.00	NAHE adjustment amount to be allocated (per wkst. B-2)					206.00

Health Financial Systems

ADVENTIST GLENOAKS HOSPITAL

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0292

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER OF PHONES)	ADMITTING (GROSS CHARGES)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
207.00 NAHE unit cost multiplier (wkst. D, Parts III and IV)			4.00	5.01	5.04	207.00

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		5A.06	5.06	7.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.04	00570	ADMITTING					5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	-18,352,339	64,526,501			5.06
7.00	00700	OPERATION OF PLANT	0	4,118,724	92,704		7.00
9.00	00900	HOUSEKEEPING	0	1,798,980	1,060	91,644	9.00
10.00	01000	DIETARY	0	543,247	3,698	3,698	10.00
11.00	01100	CAFETERIA	0	1,304,430	2,149	2,149	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,608,509	502	502	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	449,508	4,267	4,267	14.00
15.00	01500	PHARMACY	0	1,894,087	1,491	1,491	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	342,825	967	967	16.00
17.00	01700	SOCIAL SERVICE	0	790,247	430	430	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	11,849,238	30,518	30,518	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,128,344	2,999	2,999	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,867,188	4,785	4,785	40.00
43.00	04300	NURSERY	0	591,376	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,380,936	8,862	8,862	50.00
51.00	05100	RECOVERY ROOM	0	307,426	610	610	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,188,478	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	119,022	166	166	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,360,543	3,804	3,804	54.00
56.00	05600	RADIOISOTOPE	0	223,674	1,039	1,039	56.00
57.00	05700	CT SCAN	0	621,783	0	0	57.00
58.00	05800	MRI	0	228,328	1,307	1,307	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,105,862	1,595	1,595	59.00
60.00	06000	LABORATORY	0	2,577,882	2,498	2,498	60.00
65.00	06500	RESPIRATORY THERAPY	0	987,830	351	351	65.00
66.00	06600	PHYSICAL THERAPY	0	1,159,612	1,274	1,274	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	176,976	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	47,454	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	421,711	2,059	2,059	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	33,010	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,484,942	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,532,584	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,583,773	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	337,453	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	109,659	731	731	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	499,277	1,606	1,606	90.00
91.00	09100	EMERGENCY	0	3,466,410	7,798	7,798	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-18,352,339	55,241,328	86,566	85,506	123,489
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	61,279	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,091,902	1,000	1,000	192.00
192.03	19203	OP PHARMACY	0	867,429	151	151	192.03
194.00	07950	FOUNDATION	0	229,752	179	179	194.00
194.01	07951	MARKETING	0	9,194	238	238	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	0	6,025,617	4,570	4,570	194.03
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)		18,352,339	5,290,155	2,371,128	1,004,460
203.00		Unit cost multiplier (wkst. B, Part I)		0.284416	57.065013	25.873249	8.134004
204.00		Cost to be allocated (per wkst. B, Part II)		80,595	1,023,196	40,257	134,910
205.00		Unit cost multiplier (wkst. B, Part II)		0.001249	11.037237	0.439276	1.092486
206.00		NAHE adjustment amount to be allocated (per wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (wkst. D, Parts III and IV)					207.00

Cost Center Description		CAFETERIA (HOURS WORKED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.04	00570						5.04
5.06	00560						5.06
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,172,348					11.00
13.00	01300	32,502	931,880				13.00
14.00	01400	18,091	18,091	2,374,671			14.00
15.00	01500	43,285	43,285	3,010	2,540,513		15.00
16.00	01600	13,615	13,615	0	0	260,599,994	16.00
17.00	01700	12,927	12,927	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	460,722	460,722	57,753	0	33,952,367	30.00
31.00	03100	87,702	87,702	40,478	0	5,608,128	31.00
40.00	04000	99,027	99,027	6,930	0	6,727,865	40.00
43.00	04300	0	0	560	0	609,399	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	43,501	43,501	919,639	852	12,741,560	50.00
51.00	05100	12,642	12,642	178	0	1,990,582	51.00
52.00	05200	11,953	11,953	16,243	0	1,505,746	52.00
53.00	05300	2,011	2,011	12,786	7,459	3,767,355	53.00
54.00	05400	33,254	0	10,955	216	17,222,106	54.00
56.00	05600	7,840	0	14,263	1,604	2,971,928	56.00
57.00	05700	20,706	0	2,356	46	27,323,816	57.00
58.00	05800	7,432	0	26	4,614	4,617,649	58.00
59.00	05900	26,060	0	854,659	0	5,386,054	59.00
60.00	06000	60,426	0	0	0	34,613,458	60.00
65.00	06500	33,592	0	17,814	0	7,004,685	65.00
66.00	06600	0	0	479	0	3,651,507	66.00
67.00	06700	0	0	0	0	425,884	67.00
68.00	06800	0	0	0	0	266,979	68.00
69.00	06900	13,338	0	1,066	4,104	8,878,581	69.00
70.00	07000	1,185	0	0	0	270,977	70.00
71.00	07100	0	0	31,310	0	3,328,237	71.00
72.00	07200	0	0	309,525	0	5,838,428	72.00
73.00	07300	0	0	0	2,502,954	23,317,040	73.00
74.00	07400	0	0	0	0	637,673	74.00
76.00	03050	0	0	0	0	0	76.00
76.01	03060	129	0	868	0	1,442	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	10,380	10,380	2,962	5,827	2,248,619	90.00
91.00	09100	116,024	116,024	70,811	12,837	45,691,929	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,168,344	931,880	2,374,671	2,540,513	260,599,994	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,195	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
192.03	19203	2,809	0	0	0	0	192.03
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.03	07953	0	0	0	0	0	194.03
200.00							200.00
201.00							201.00
202.00		1,853,666	2,159,021	1,001,771	2,726,452	573,602	202.00
203.00		1.581157	2.316844	0.421857	1.073190	0.002201	203.00
204.00		79,634	23,075	157,254	61,517	36,937	204.00
205.00		0.067927	0.024762	0.066221	0.024214	0.000142	205.00
206.00							206.00
207.00							207.00

Cost Center Description		SOCIAL SERVICE	
		(TOTAL PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	01160	COMMUNICATIONS	5.01
5.04	00570	ADMITTING	5.04
5.06	00560	OTHER ADMINISTRATIVE AND GENERAL	5.06
7.00	00700	OPERATION OF PLANT	7.00
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
		29,726	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
		22,154	
		2,534	
		4,425	
		613	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	76.00
76.01	03060	WOUND CARE	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		29,726	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.03	19203	OP PHARMACY	192.03
194.00	07950	FOUNDATION	194.00
194.01	07951	MARKETING	194.01
194.03	07953	THERAPEUTIC DAY SCHOOL	194.03
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)	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	205.00
206.00		NAHE adjustment amount to be allocated (per wkst. B-2)	206.00
207.00		NAHE unit cost multiplier (wkst. D, Parts III and IV)	207.00
		1,101,059	
		37.040268	
		18,081	
		0.608255	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Total Costs			
				Hospital					
				Costs	PPS				
				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	21,230,842			21,230,842	0	21,230,842	30.00
31.00	03100	INTENSIVE CARE UNIT	4,819,222			4,819,222	0	4,819,222	31.00
40.00	04000	SUBPROVIDER - IPF	4,799,536			4,799,536	0	4,799,536	40.00
43.00	04300	NURSERY	783,856			783,856	0	783,856	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	4,379,592			4,379,592	0	4,379,592	50.00
51.00	05100	RECOVERY ROOM	499,191			499,191	0	499,191	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,583,259			1,583,259	0	1,583,259	52.00
53.00	05300	ANESTHESIOLOGY	196,172			196,172	0	196,172	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,158,339			2,158,339	0	2,158,339	54.00
56.00	05600	RADIOISOTOPE	400,138			400,138	0	400,138	56.00
57.00	05700	CT SCAN	892,550			892,550	0	892,550	57.00
58.00	05800	MRI	428,545			428,545	0	428,545	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,966,278			1,966,278	0	1,966,278	59.00
60.00	06000	LABORATORY	3,689,979			3,689,979	0	3,689,979	60.00
65.00	06500	RESPIRATORY THERAPY	1,373,943	0		1,373,943	0	1,373,943	65.00
66.00	06600	PHYSICAL THERAPY	1,603,327	0		1,603,327	0	1,603,327	66.00
67.00	06700	OCCUPATIONAL THERAPY	228,248	0		228,248	0	228,248	67.00
68.00	06800	SPEECH PATHOLOGY	61,539	0		61,539	0	61,539	68.00
69.00	06900	ELECTROCARDIOLOGY	757,907			757,907	0	757,907	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	44,869			44,869	0	44,869	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,212,232			3,212,232	0	3,212,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,111,900			2,111,900	0	2,111,900	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,056,105			6,056,105	0	6,056,105	73.00
74.00	07400	RENAL DIALYSIS	434,834			434,834	0	434,834	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0			0	0	0	76.00
76.01	03060	WOUND CARE	202,049			202,049	0	202,049	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	827,390			827,390	0	827,390	90.00
91.00	09100	EMERGENCY	5,695,568			5,695,568	0	5,695,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,261,918			1,261,918	0	1,261,918	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	71,699,328	0		71,699,328	0	71,699,328	200.00
201.00		Less Observation Beds	1,261,918			1,261,918	0	1,261,918	201.00
202.00		Total (see instructions)	70,437,410	0		70,437,410	0	70,437,410	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 9:38 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	30,861,450		30,861,450	30.00
31.00	03100	INTENSIVE CARE UNIT	5,608,128		5,608,128	31.00
40.00	04000	SUBPROVIDER - IPF	6,727,865		6,727,865	40.00
43.00	04300	NURSERY	609,399		609,399	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,817,862	7,923,698	12,741,560	0.343725 50.00
51.00	05100	RECOVERY ROOM	731,164	1,259,418	1,990,582	0.250776 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,228,852	276,894	1,505,746	1.051478 52.00
53.00	05300	ANESTHESIOLOGY	1,533,095	2,234,260	3,767,355	0.052072 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,264,770	11,957,336	17,222,106	0.125324 54.00
56.00	05600	RADIOISOTOPE	1,212,986	1,758,942	2,971,928	0.134639 56.00
57.00	05700	CT SCAN	9,627,105	17,696,711	27,323,816	0.032666 57.00
58.00	05800	MRI	1,794,585	2,823,064	4,617,649	0.092806 58.00
59.00	05900	CARDIAC CATHETERIZATION	3,948,667	1,437,387	5,386,054	0.365068 59.00
60.00	06000	LABORATORY	21,048,862	13,564,596	34,613,458	0.106605 60.00
65.00	06500	RESPIRATORY THERAPY	6,542,315	462,370	7,004,685	0.196146 65.00
66.00	06600	PHYSICAL THERAPY	757,640	2,893,867	3,651,507	0.439086 66.00
67.00	06700	OCCUPATIONAL THERAPY	404,792	21,092	425,884	0.535939 67.00
68.00	06800	SPEECH PATHOLOGY	251,578	15,401	266,979	0.230501 68.00
69.00	06900	ELECTROCARDIOLOGY	5,087,585	3,790,996	8,878,581	0.085364 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	220,307	50,670	270,977	0.165582 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,469,817	1,858,420	3,328,237	0.965145 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,166,304	2,672,124	5,838,428	0.361724 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,699,752	8,617,288	23,317,040	0.259729 73.00
74.00	07400	RENAL DIALYSIS	637,673	0	637,673	0.681907 74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000 76.00
76.01	03060	WOUND CARE	0	1,442	1,442	140.117198 76.01
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	19,326	2,229,293	2,248,619	0.367955 90.00
91.00	09100	EMERGENCY	10,965,355	34,726,574	45,691,929	0.124652 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	993,376	2,097,541	3,090,917	0.408267 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	140,230,610	120,369,384	260,599,994	200.00
201.00		Less observation Beds				201.00
202.00		Total (see instructions)	140,230,610	120,369,384	260,599,994	202.00

Cost Center Description		PPS Inpatient Ratio	
		11.00	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS		30.00
31.00	03100 INTENSIVE CARE UNIT		31.00
40.00	04000 SUBPROVIDER - IPF		40.00
43.00	04300 NURSERY		43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.343725	50.00
51.00	05100 RECOVERY ROOM	0.250776	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.051478	52.00
53.00	05300 ANESTHESIOLOGY	0.052072	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.125324	54.00
56.00	05600 RADIOISOTOPE	0.134639	56.00
57.00	05700 CT SCAN	0.032666	57.00
58.00	05800 MRI	0.092806	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.365068	59.00
60.00	06000 LABORATORY	0.106605	60.00
65.00	06500 RESPIRATORY THERAPY	0.196146	65.00
66.00	06600 PHYSICAL THERAPY	0.439086	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.535939	67.00
68.00	06800 SPEECH PATHOLOGY	0.230501	68.00
69.00	06900 ELECTROCARDIOLOGY	0.085364	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.165582	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.965145	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.361724	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.259729	73.00
74.00	07400 RENAL DIALYSIS	0.681907	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	76.00
76.01	03060 WOUND CARE	140.117198	76.01
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.367955	90.00
91.00	09100 EMERGENCY	0.124652	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.408267	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
200.00	Subtotal (see instructions)		200.00
201.00	Less Observation Beds		201.00
202.00	Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Total Costs	Hospital		Total Costs
				Costs			RCE Disallowance	Total Costs	
				3.00	4.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000 ADULTS & PEDIATRICS	21,230,842			21,230,842		0	21,230,842	30.00
31.00	03100 INTENSIVE CARE UNIT	4,819,222			4,819,222		0	4,819,222	31.00
40.00	04000 SUBPROVIDER - IPF	4,799,536			4,799,536		0	4,799,536	40.00
43.00	04300 NURSERY	783,856			783,856		0	783,856	43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000 OPERATING ROOM	4,379,592			4,379,592		0	4,379,592	50.00
51.00	05100 RECOVERY ROOM	499,191			499,191		0	499,191	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,583,259			1,583,259		0	1,583,259	52.00
53.00	05300 ANESTHESIOLOGY	196,172			196,172		0	196,172	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,158,339			2,158,339		0	2,158,339	54.00
56.00	05600 RADIOISOTOPE	400,138			400,138		0	400,138	56.00
57.00	05700 CT SCAN	892,550			892,550		0	892,550	57.00
58.00	05800 MRI	428,545			428,545		0	428,545	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,966,278			1,966,278		0	1,966,278	59.00
60.00	06000 LABORATORY	3,689,979			3,689,979		0	3,689,979	60.00
65.00	06500 RESPIRATORY THERAPY	1,373,943	0		1,373,943		0	1,373,943	65.00
66.00	06600 PHYSICAL THERAPY	1,603,327	0		1,603,327		0	1,603,327	66.00
67.00	06700 OCCUPATIONAL THERAPY	228,248	0		228,248		0	228,248	67.00
68.00	06800 SPEECH PATHOLOGY	61,539	0		61,539		0	61,539	68.00
69.00	06900 ELECTROCARDIOLOGY	757,907			757,907		0	757,907	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	44,869			44,869		0	44,869	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,212,232			3,212,232		0	3,212,232	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,111,900			2,111,900		0	2,111,900	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,056,105			6,056,105		0	6,056,105	73.00
74.00	07400 RENAL DIALYSIS	434,834			434,834		0	434,834	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0			0		0	0	76.00
76.01	03060 WOUND CARE	202,049			202,049		0	202,049	76.01
OUTPATIENT SERVICE COST CENTERS									
90.00	09000 CLINIC	827,390			827,390		0	827,390	90.00
91.00	09100 EMERGENCY	5,695,568			5,695,568		0	5,695,568	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,261,918			1,261,918		0	1,261,918	92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300 INTEREST EXPENSE								113.00
200.00	Subtotal (see instructions)	71,699,328	0		71,699,328		0	71,699,328	200.00
201.00	Less Observation Beds	1,261,918			1,261,918		0	1,261,918	201.00
202.00	Total (see instructions)	70,437,410	0		70,437,410		0	70,437,410	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 9:38 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	30,861,450		30,861,450		30.00
31.00	03100	INTENSIVE CARE UNIT	5,608,128		5,608,128		31.00
40.00	04000	SUBPROVIDER - IPF	6,727,865		6,727,865		40.00
43.00	04300	NURSERY	609,399		609,399		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,817,862	7,923,698	12,741,560	0.343725	50.00
51.00	05100	RECOVERY ROOM	731,164	1,259,418	1,990,582	0.250776	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,228,852	276,894	1,505,746	1.051478	52.00
53.00	05300	ANESTHESIOLOGY	1,533,095	2,234,260	3,767,355	0.052072	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,264,770	11,957,336	17,222,106	0.125324	54.00
56.00	05600	RADIOISOTOPE	1,212,986	1,758,942	2,971,928	0.134639	56.00
57.00	05700	CT SCAN	9,627,105	17,696,711	27,323,816	0.032666	57.00
58.00	05800	MRI	1,794,585	2,823,064	4,617,649	0.092806	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,948,667	1,437,387	5,386,054	0.365068	59.00
60.00	06000	LABORATORY	21,048,862	13,564,596	34,613,458	0.106605	60.00
65.00	06500	RESPIRATORY THERAPY	6,542,315	462,370	7,004,685	0.196146	65.00
66.00	06600	PHYSICAL THERAPY	757,640	2,893,867	3,651,507	0.439086	66.00
67.00	06700	OCCUPATIONAL THERAPY	404,792	21,092	425,884	0.535939	67.00
68.00	06800	SPEECH PATHOLOGY	251,578	15,401	266,979	0.230501	68.00
69.00	06900	ELECTROCARDIOLOGY	5,087,585	3,790,996	8,878,581	0.085364	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	220,307	50,670	270,977	0.165582	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,469,817	1,858,420	3,328,237	0.965145	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,166,304	2,672,124	5,838,428	0.361724	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,699,752	8,617,288	23,317,040	0.259729	73.00
74.00	07400	RENAL DIALYSIS	637,673	0	637,673	0.681907	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	1,442	1,442	140.117198	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	19,326	2,229,293	2,248,619	0.367955	90.00
91.00	09100	EMERGENCY	10,965,355	34,726,574	45,691,929	0.124652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	993,376	2,097,541	3,090,917	0.408267	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	140,230,610	120,369,384	260,599,994		200.00
201.00		Less observation Beds					201.00
202.00		Total (see instructions)	140,230,610	120,369,384	260,599,994		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0292

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 9:38 am

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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000		76.00
76.01	03060	WOUND CARE	0.000000		76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-0292

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

Worksheet D
Part I
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		Title XVIII			Hospital	Per Diem (col. 3 / col. 4)	PPS	
		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,296,456	0	1,296,456	23,554	55.04	30.00	
31.00	INTENSIVE CARE UNIT	139,075		139,075	2,534	54.88	31.00	
40.00	SUBPROVIDER - IPF	212,552	0	212,552	4,425	48.03	40.00	
43.00	NURSERY	1,475		1,475	613	2.41	43.00	
200.00	Total (lines 30 through 199)	1,649,558		1,649,558	31,126		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,840	376,474					30.00
31.00	INTENSIVE CARE UNIT	930	51,038					31.00
40.00	SUBPROVIDER - IPF	2,848	136,789					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	10,618	564,301					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0292

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	392,762	12,741,560	0.030825	1,471,430	45,357	50.00
51.00	05100 RECOVERY ROOM	24,216	1,990,582	0.012165	238,465	2,901	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,565	1,505,746	0.003032	243	1	52.00
53.00	05300 ANESTHESIOLOGY	8,124	3,767,355	0.002156	461,271	995	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	146,515	17,222,106	0.008507	2,118,557	18,023	54.00
56.00	05600 RADIOISOTOPE	40,153	2,971,928	0.013511	520,695	7,035	56.00
57.00	05700 CT SCAN	7,715	27,323,816	0.000282	3,302,942	931	57.00
58.00	05800 MRI	49,298	4,617,649	0.010676	543,009	5,797	58.00
59.00	05900 CARDIAC CATHETERIZATION	119,054	5,386,054	0.022104	1,221,018	26,989	59.00
60.00	06000 LABORATORY	105,267	34,613,458	0.003041	7,044,729	21,423	60.00
65.00	06500 RESPIRATORY THERAPY	19,158	7,004,685	0.002735	2,748,642	7,518	65.00
66.00	06600 PHYSICAL THERAPY	48,411	3,651,507	0.013258	326,780	4,332	66.00
67.00	06700 OCCUPATIONAL THERAPY	301	425,884	0.000707	171,507	121	67.00
68.00	06800 SPEECH PATHOLOGY	109	266,979	0.000408	134,325	55	68.00
69.00	06900 ELECTROCARDIOLOGY	78,200	8,878,581	0.008808	1,955,788	17,227	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	186	270,977	0.000686	67,524	46	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,803	3,328,237	0.001744	477,025	832	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	23,509	5,838,428	0.004027	1,292,007	5,203	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	68,218	23,317,040	0.002926	5,137,619	15,033	73.00
74.00	07400 RENAL DIALYSIS	541	637,673	0.000848	316,278	268	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060 WOUND CARE	26,737	1,442	18.541609	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	60,860	2,248,619	0.027066	2,649	72	90.00
91.00	09100 EMERGENCY	312,891	45,691,929	0.006848	3,773,790	25,843	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	77,059	3,090,917	0.024931	391,590	9,763	92.00
200.00	Total (lines 50 through 199)	1,619,652	216,793,152		33,717,883	215,765	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0292	Period: From 01/01/2017 To 12/31/2017	worksheet D Part III Date/Time Prepared: 5/29/2018 9:38 am
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Cost Center Description		Title XVIII			Hospital	PPS		
		Nursing School Post-Stepdown Adjustments 1A	Nursing School 1.00	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2.00	All Other Medical Education Cost 3.00		
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
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00	Total (lines 30 through 199)		0	0	0	0	0	200.00
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	23,554	0.00	6,840	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,534	0.00	930	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,425	0.00	2,848	40.00
43.00	04300	NURSERY	0	0	613	0.00	0	43.00
200.00	Total (lines 30 through 199)		0	0	31,126		10,618	200.00
Cost Center Description		Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost					
		9.00	13.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
43.00	04300	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)		0	0				200.00

Health Financial Systems

ADVENTIST GLENOAKS HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description	Title XVIII			Hospital		PPS		
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060	WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D Part IV Date/Time Prepared: 5/29/2018 9:38 am

Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	12,741,560	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,990,582	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,505,746	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,767,355	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,222,106	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,971,928	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	27,323,816	0.000000	57.00
58.00	05800	MRI	0	0	0	4,617,649	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	5,386,054	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	34,613,458	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,004,685	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,651,507	0.000000	66.00
66.00	06600	PHYSICAL THERAPY	0	0	0	425,884	0.000000	67.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	266,979	0.000000	68.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	8,878,581	0.000000	69.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	270,977	0.000000	70.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,328,237	0.000000	71.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,838,428	0.000000	72.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,317,040	0.000000	73.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	637,673	0.000000	74.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	76.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	1,442	0.000000	76.01
76.01	03060	WOUND CARE	0	0	0			
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,248,619	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	45,691,929	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,090,917	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	216,793,152		200.00

Health Financial Systems

ADVENTIST GLENOAKS HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D Part IV Date/Time Prepared: 5/29/2018 9:38 am

Cost Center Description		Title XVIII			Hospital	PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	1,471,430	0	1,983,849	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	238,465	0	354,810	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	243	0	908	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	461,271	0	515,991	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,118,557	0	1,487,208	0 54.00
56.00	05600	RADIOISOTOPE	0.000000	520,695	0	484,431	0 56.00
57.00	05700	CT SCAN	0.000000	3,302,942	0	3,467,906	0 57.00
58.00	05800	MRI	0.000000	543,009	0	639,641	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,221,018	0	498,905	0 59.00
60.00	06000	LABORATORY	0.000000	7,044,729	0	177,823	0 60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,748,642	0	84,570	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	326,780	0	7,365	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	171,507	0	4,590	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	134,325	0	2,400	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,955,788	0	780,558	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	67,524	0	8,973	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	477,025	0	414,433	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,292,007	0	1,068,104	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,137,619	0	2,283,568	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	316,278	0	0	0 74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0 76.00
76.01	03060	WOUND CARE	0.000000	0	0	1,442	0 76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	2,649	0	301,410	0 90.00
91.00	09100	EMERGENCY	0.000000	3,773,790	0	3,847,209	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	391,590	0	339,605	0 92.00
200.00		Total (lines 50 through 199)		33,717,883	0	18,755,699	0 200.00

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
		21.00	24.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0		56.00
57.00	05700 CT SCAN	0	0		57.00
58.00	05800 MRI	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000 LABORATORY	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0		74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0		76.00
76.01	03060 WOUND CARE	0	0		76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00	Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0292

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

Worksheet D
Part V
Date/Time Prepared:
5/29/2018 9:38 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.)	3.00	4.00	PPS Services (see inst.)	5.00	
								2.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.343725	1,983,849	0	0	0	681,898	50.00
51.00	05100 RECOVERY ROOM	0.250776	354,810	0	0	0	88,978	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.051478	908	0	0	0	955	52.00
53.00	05300 ANESTHESIOLOGY	0.052072	515,991	0	0	0	26,869	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.125324	1,487,208	0	0	0	186,383	54.00
56.00	05600 RADIOISOTOPE	0.134639	484,431	0	0	0	65,223	56.00
57.00	05700 CT SCAN	0.032666	3,467,906	0	0	0	113,283	57.00
58.00	05800 MRI	0.092806	639,641	0	0	0	59,363	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.365068	498,905	0	0	0	182,134	59.00
60.00	06000 LABORATORY	0.106605	177,823	0	0	0	18,957	60.00
65.00	06500 RESPIRATORY THERAPY	0.196146	84,570	0	0	0	16,588	65.00
66.00	06600 PHYSICAL THERAPY	0.439086	7,365	0	0	0	3,234	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.535939	4,590	0	0	0	2,460	67.00
68.00	06800 SPEECH PATHOLOGY	0.230501	2,400	0	0	0	553	68.00
69.00	06900 ELECTROCARDIOLOGY	0.085364	780,558	0	0	0	66,632	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.165582	8,973	0	0	0	1,486	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.965145	414,433	0	0	0	399,988	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.361724	1,068,104	0	0	0	386,359	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.259729	2,283,568	0	0	46,282	593,109	73.00
74.00	07400 RENAL DIALYSIS	0.681907	0	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	140.117198	1,442	0	0	0	202,049	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.367955	301,410	0	0	0	110,905	90.00
91.00	09100 EMERGENCY	0.124652	3,847,209	0	0	0	479,562	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.408267	339,605	0	0	0	138,650	92.00
200.00	Subtotal (see instructions)		18,755,699	0	0	46,282	3,825,618	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		18,755,699	0	0	46,282	3,825,618	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0292

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

Worksheet D
Part V
Date/Time Prepared:
5/29/2018 9:38 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
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	12,021		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03050 BACTERIOLOGY & MICROBIOLOGY	0	0		76.00
76.01 03060 WOUND CARE	0	0		76.01
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	12,021		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0	0		201.00
202.00 Net Charges (line 200 - line 201)	0	12,021		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2017 To 12/31/2017		worksheet D Part II Date/Time Prepared: 5/29/2018 9:38 am		
Title XVIII				Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	392,762	12,741,560	0.030825	60	2	50.00
51.00	05100	RECOVERY ROOM	24,216	1,990,582	0.012165	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,565	1,505,746	0.003032	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,124	3,767,355	0.002156	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,515	17,222,106	0.008507	43,974	374	54.00
56.00	05600	RADIOISOTOPE	40,153	2,971,928	0.013511	0	0	56.00
57.00	05700	CT SCAN	7,715	27,323,816	0.000282	83,650	24	57.00
58.00	05800	MRI	49,298	4,617,649	0.010676	17,500	187	58.00
59.00	05900	CARDIAC CATHETERIZATION	119,054	5,386,054	0.022104	0	0	59.00
60.00	06000	LABORATORY	105,267	34,613,458	0.003041	734,490	2,234	60.00
65.00	06500	RESPIRATORY THERAPY	19,158	7,004,685	0.002735	145,790	399	65.00
66.00	06600	PHYSICAL THERAPY	48,411	3,651,507	0.013258	42,092	558	66.00
67.00	06700	OCCUPATIONAL THERAPY	301	425,884	0.000707	22,575	16	67.00
68.00	06800	SPEECH PATHOLOGY	109	266,979	0.000408	5,700	2	68.00
69.00	06900	ELECTROCARDIOLOGY	78,200	8,878,581	0.008808	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	186	270,977	0.000686	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,803	3,328,237	0.001744	64	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,509	5,838,428	0.004027	1,104	4	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,218	23,317,040	0.002926	660,575	1,933	73.00
74.00	07400	RENAL DIALYSIS	541	637,673	0.000848	15,150	13	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060	WOUND CARE	26,737	1,442	18.541609	0	0	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	60,860	2,248,619	0.027066	0	0	90.00
91.00	09100	EMERGENCY	312,891	45,691,929	0.006848	134,675	922	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,090,917	0.000000	1,620	0	92.00
200.00		Total (lines 50 through 199)	1,542,593	216,793,152		1,909,019	6,668	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 9:38 am

Component CCN: 14-S292

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 9:38 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	12,741,560	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,990,582	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,505,746	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,767,355	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,222,106	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,971,928	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	27,323,816	0.000000	57.00
58.00	05800	MRI	0	0	0	4,617,649	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	5,386,054	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	34,613,458	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,004,685	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,651,507	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	425,884	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	266,979	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,878,581	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	270,977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,328,237	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,838,428	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,317,040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	637,673	0.000000	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	0	0	1,442	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,248,619	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	45,691,929	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,090,917	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	216,793,152		200.00

ADVENTIST GLENOAKS HOSPITAL

Health Financial Systems

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

Component CCN: 14-s292

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

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Title XVIII

Subprovider - IPF

PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	60	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	43,974	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	83,650	0	0	0	57.00
58.00	05800 MRI	0.000000	17,500	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	734,490	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	145,790	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	42,092	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	22,575	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	5,700	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	64	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,104	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	660,575	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	15,150	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03060 WOUND CARE	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	134,675	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,620	0	0	0	92.00
200.00	Total (lines 50 through 199)		1,909,019	0	0	0	200.00

Health Financial Systems

ADVENTIST GLENOAKS HOSPITAL

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 9:38 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
		21.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2018 9:38 am

Title XIX

Subprovider -
IPF

TEFRA

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	392,762	12,741,560	0.030825	0	0	50.00
51.00	05100 RECOVERY ROOM	24,216	1,990,582	0.012165	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,565	1,505,746	0.003032	0	0	52.00
53.00	05300 ANESTHESIOLOGY	8,124	3,767,355	0.002156	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	146,515	17,222,106	0.008507	0	0	54.00
56.00	05600 RADIOISOTOPE	40,153	2,971,928	0.013511	0	0	56.00
57.00	05700 CT SCAN	7,715	27,323,816	0.000282	0	0	57.00
58.00	05800 MRI	49,298	4,617,649	0.010676	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	119,054	5,386,054	0.022104	0	0	59.00
60.00	06000 LABORATORY	105,267	34,613,458	0.003041	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	19,158	7,004,685	0.002735	0	0	65.00
66.00	06600 PHYSICAL THERAPY	48,411	3,651,507	0.013258	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	301	425,884	0.000707	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	109	266,979	0.000408	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	78,200	8,878,581	0.008808	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	186	270,977	0.000686	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,803	3,328,237	0.001744	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	23,509	5,838,428	0.004027	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	68,218	23,317,040	0.002926	0	0	73.00
74.00	07400 RENAL DIALYSIS	541	637,673	0.000848	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0.000000	0	0	76.00
76.01	03060 WOUND CARE	26,737	1,442	18.541609	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	60,860	2,248,619	0.027066	0	0	90.00
91.00	09100 EMERGENCY	312,891	45,691,929	0.006848	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	3,090,917	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	1,542,593	216,793,152		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
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Component CCN: 14-S292

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0	76.00
76.01	03060 WOUND CARE	0	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 9:38 am

Component CCN: 14-S292

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	12,741,560	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,990,582	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,505,746	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,767,355	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	17,222,106	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	2,971,928	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	27,323,816	0.000000	57.00
58.00	05800	MRI	0	0	0	4,617,649	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	5,386,054	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	34,613,458	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,004,685	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,651,507	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	425,884	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	266,979	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	8,878,581	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	270,977	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,328,237	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,838,428	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,317,040	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	637,673	0.000000	74.00
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0	0	0	0	0.000000	76.00
76.01	03060	WOUND CARE	0	0	0	1,442	0.000000	76.01
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	2,248,619	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	45,691,929	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,090,917	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	216,793,152		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 9:38 am

Component CCN: 14-S292

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	0	0	76.00
76.01	03060 WOUND CARE	0.000000	0	0	0	0	76.01
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 9:38 am

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost 21.00	PSA Adj. All Other Medical Education Cost 24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0	0	76.00
76.01	03060 WOUND CARE	0	0	76.01
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1

Date/Time Prepared:
5/29/2018 9:38 am

Title XVIII		Hospital	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)	23,554	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	23,554	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)	22,154	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)	6,840	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)	21,230,842	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)	21,230,842	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)	21,230,842	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)	901.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,165,371	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)	6,165,371	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description	Title XVIII			Hospital Program Days	PPS Program Cost (col. 3 x col. 4)	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)			
	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	4,819,222	2,534	1,901.82	930	1,768,693	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)					6,373,202	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					14,307,266	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)					427,512	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					215,765	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					643,277	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,663,989	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)					1,400	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					901.37	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,261,918	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1

Date/Time Prepared:
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Cost Center Description	Title XVIII			Hospital	PPS	
	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,296,456	21,230,842	0.061065	1,261,918	77,059	90.00
91.00 Nursing School cost	0	21,230,842	0.000000	1,261,918	0	91.00
92.00 Allied health cost	0	21,230,842	0.000000	1,261,918	0	92.00
93.00 All other Medical Education	0	21,230,842	0.000000	1,261,918	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0292 Component CCN: 14-S292	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 9:38 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,425	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,425	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)	4,425	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,848	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,799,536	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,799,536	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,799,536	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)	1,084.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,089,055	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)	3,089,055	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

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

Worksheet D-1

Component CCN: 14-S292

Date/Time Prepared:
5/29/2018 9:38 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title v & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					348,491	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,437,546	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)					136,789	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					6,668	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					143,457	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,294,089	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0292 Component CCN: 14-S292		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 9:38 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00 Capital-related cost	212,552	4,799,536	0.044286	0	0	0	90.00
91.00 Nursing School cost	0	4,799,536	0.000000	0	0	0	91.00
92.00 Allied health cost	0	4,799,536	0.000000	0	0	0	92.00
93.00 All other Medical Education	0	4,799,536	0.000000	0	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0292	Period: From 01/01/2017 To 12/31/2017	worksheet D-1
	Component CCN: 14-S292		Date/Time Prepared: 5/29/2018 9:38 am
	Title XIX	Subprovider - IPF	TEFRA

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)	4,425	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,425	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)	4,425	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)	43	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)	613	15.00
16.00	Nursery days (title V or XIX only)	89	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,799,536	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,799,536	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,799,536	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)	1,084.64	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	46,640	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)	46,640	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292

Period: From 01/01/2017

Worksheet D-1

Component CCN: 14-S292

To 12/31/2017

Date/Time Prepared: 5/29/2018 9:38 am

Title XIX

Subprovider - IPF

TEFRA

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title v & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					46,640	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					46,640	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					4	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)					-46,640	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title v or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title v or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title v or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0292
Component CCN: 14-S292

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

Worksheet D-1
Date/Time Prepared:
5/29/2018 9:38 am

Title XIX

Subprovider -
IPF

TEFRA

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	4,799,536	0.000000	0	0	90.00
91.00 Nursing School cost	0	4,799,536	0.000000	0	0	91.00
92.00 Allied health cost	0	4,799,536	0.000000	0	0	92.00
93.00 All other Medical Education	0	4,799,536	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0292

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

Worksheet D-3

Date/Time Prepared:
5/29/2018 9:38 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	PPS
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		8,769,399		30.00
31.00	03100 INTENSIVE CARE UNIT		2,107,111		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.343725	1,471,430	505,767	50.00
51.00	05100 RECOVERY ROOM	0.250776	238,465	59,801	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.051478	243	256	52.00
53.00	05300 ANESTHESIOLOGY	0.052072	461,271	24,019	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.125324	2,118,557	265,506	54.00
56.00	05600 RADIOISOTOPE	0.134639	520,695	70,106	56.00
57.00	05700 CT SCAN	0.032666	3,302,942	107,894	57.00
58.00	05800 MRI	0.092806	543,009	50,394	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.365068	1,221,018	445,755	59.00
60.00	06000 LABORATORY	0.106605	7,044,729	751,003	60.00
65.00	06500 RESPIRATORY THERAPY	0.196146	2,748,642	539,135	65.00
66.00	06600 PHYSICAL THERAPY	0.439086	326,780	143,485	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.535939	171,507	91,917	67.00
68.00	06800 SPEECH PATHOLOGY	0.230501	134,325	30,962	68.00
69.00	06900 ELECTROCARDIOLOGY	0.085364	1,955,788	166,954	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.165582	67,524	11,181	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.965145	477,025	460,398	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.361724	1,292,007	467,350	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.259729	5,137,619	1,334,389	73.00
74.00	07400 RENAL DIALYSIS	0.681907	316,278	215,672	74.00
76.00	03050 BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0	76.00
76.01	03060 WOUND CARE	140.117198	0	0	76.01
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.367955	2,649	975	90.00
91.00	09100 EMERGENCY	0.124652	3,773,790	470,410	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.408267	391,590	159,873	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		33,717,883	6,373,202	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)		33,717,883	6,373,202	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0292	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3	
		Component CCN: 14-S292		Date/Time Prepared: 5/29/2018 9:38 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		4,328,960	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.343725	60	21
51.00	05100	RECOVERY ROOM	0.250776	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.051478	0	0
53.00	05300	ANESTHESIOLOGY	0.052072	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.125324	43,974	5,511
56.00	05600	RADIOISOTOPE	0.134639	0	0
57.00	05700	CT SCAN	0.032666	83,650	2,733
58.00	05800	MRI	0.092806	17,500	1,624
59.00	05900	CARDIAC CATHETERIZATION	0.365068	0	0
60.00	06000	LABORATORY	0.106605	734,490	78,300
65.00	06500	RESPIRATORY THERAPY	0.196146	145,790	28,596
66.00	06600	PHYSICAL THERAPY	0.439086	42,092	18,482
67.00	06700	OCCUPATIONAL THERAPY	0.535939	22,575	12,099
68.00	06800	SPEECH PATHOLOGY	0.230501	5,700	1,314
69.00	06900	ELECTROCARDIOLOGY	0.085364	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.165582	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.965145	64	62
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.361724	1,104	399
73.00	07300	DRUGS CHARGED TO PATIENTS	0.259729	660,575	171,570
74.00	07400	RENAL DIALYSIS	0.681907	15,150	10,331
76.00	03050	BACTERIOLOGY & MICROBIOLOGY	0.000000	0	0
76.01	03060	WOUND CARE	140.117198	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.367955	0	0
91.00	09100	EMERGENCY	0.124652	134,675	16,788
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.408267	1,620	661
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,909,019	348,491
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		1,909,019	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0292

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

Worksheet E
Part A
Date/Time Prepared:
5/29/2018 9:38 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)		7,900,879	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		2,892,567	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)		177,056	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		123.07	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		6.26	30.00
31.00	Percentage of Medicaid patient days (see instructions)		39.92	31.00
32.00	Sum of lines 30 and 31		46.18	32.00
33.00	Allowable disproportionate share percentage (see instructions)		27.31	33.00
34.00	Disproportionate share adjustment (see instructions)		736,923	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0292

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

Worksheet E
Part A
Date/Time Prepared:
5/29/2018 9:38 am

		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)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000283369	0.000222958	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,693,832	1,508,691	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,266,893	380,273	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,647,166		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)	13,354,591		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)		13,354,591	49.00
50.00	Payment for inpatient program capital (from wkst. L, Pt. I and Pt. II, as applicable)		967,645	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		0	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)		14,322,236	59.00
60.00	Primary payer payments		9,573	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,312,663	61.00
62.00	Deductibles billed to program beneficiaries		1,149,736	62.00
63.00	Coinsurance billed to program beneficiaries		126,609	63.00
64.00	Allowable bad debts (see instructions)		327,506	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		212,879	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		265,071	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		13,249,197	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-6,866	70.93
70.94	HRR adjustment amount (see instructions)		-42,072	70.94
70.95	Recovery of accelerated depreciation		0	70.95

		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	0	70.98
70.99	HAC adjustment amount (see instructions)		13,200,259	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		264,005	0	71.00
71.01	Sequestration adjustment (see instructions)		0	0	71.01
71.02	Demonstration payment adjustment amount after sequestration		12,965,432	0	71.02
72.00	Interim payments		0	0	72.00
73.00	Tentative settlement (for contractor use only)		-29,178	0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		476,731	0	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				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)			0.00	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0	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	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	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	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0292

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

worksheet DSH

Date/Time Prepared: 5/29/2018 9:38 am

		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	6.26	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	39.92	0.00			39.92	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	46.18	0.00			39.92	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (worksheet E, Part A, Line 4)	123.07	0.00			123.07	5.00
6.00	Disproportionate Share Payment Percentage (transferred from worksheet E, Part A, line 33)	27.31	0.00			22.15	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	6.26	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (worksheet S-2, line 24, column 1)	1,437	0			1,437	15.00
16.00	In-State Medicaid eligible unpaid paid days (worksheet S-2, line 24, column 2)	1,644	0			1,644	16.00
17.00	Out-of-State Medicaid paid days (worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (worksheet S-2, line 24, column 4)	69	0			69	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (worksheet S-2, line 24, column 5)	6,907	0			6,907	19.00
20.00	Other Medicaid days (worksheet S-2, line 24, column 6)	96	0			96	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	10,153	0			10,153	21.00
22.00	Total patient days (worksheet S-3, Part I, Column 8, Line 14)	25,301	0			25,301	22.00
23.00	Plus total labor room days (worksheet S-3, Part I, Column 8, Line 32)	78	0			78	23.00
24.00	Plus total employee discount days (worksheet S-3, Part I, Column 8, Line 30)	57	0			57	24.00
25.00	Less total Swing-bed SNF and NF patient days (worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	25,436	0			25,436	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	39.92	0.00			39.92	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0292

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

Worksheet DSH

Date/Time Prepared:
5/29/2018 9:38 am

		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcrx Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	27.31		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		27.31		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		27.31		0.00		31.00
		Original .mcrx Values	Adjusted .mcrx Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE

Provider CCN: 14-0292

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

Worksheet DSH

Date/Time Prepared:
5/29/2018 9:38 am

Title XVIII

Hospital

PPS

		Revised Percentage 6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	22.15	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	22.15	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	22.15	31.00

		Title XVIII					Hospital		PPS	
		W/S E, Part A Line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)			
		0	1.00	2.00	3.00	4.00	5.00	0	1.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,900,879	0	7,900,879		7,900,879	1.01		
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,892,567	0		2,892,567	2,892,567	1.02		
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0			0	1.03	
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	0	1.04	
2.00	Outlier payments for discharges (see instructions)	2.00	177,056	0	107,707	69,349	177,056	2.00		
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	0	2.01	
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	0	3.00	
4.00	Managed care simulated payments	3.00	0	0	0	0	0	0	4.00	
Indirect Medical Education Adjustment										
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000		5.00	
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	0	6.00	
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	0	6.01	
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA										
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000		7.00	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	0	8.00	
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	0	8.01	
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	0	9.00	
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	0	9.01	
Disproportionate Share Adjustment										
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2731	0.2731	0.2731	0.2731	0.2731		10.00	
11.00	Disproportionate share adjustment (see instructions)	34.00	736,923	0	539,433	197,490	736,923		11.00	
11.01	Uncompensated care payments	36.00	1,647,166	0	1,266,893	380,273	1,647,166		11.01	
Additional payment for high percentage of ESRD beneficiary discharges										
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	0	12.00	
13.00	Subtotal (see instructions)	47.00	13,354,591	0	9,814,912	3,539,679	13,354,591		13.00	
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	0	14.00	
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,354,591	0	9,814,912	3,539,679	13,354,591		15.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	967,645	0	706,002	261,643	967,645		16.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	0	17.00	
17.01	Net organ acquisition cost								17.01	
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	0	17.02	

		Title XVIII			Hospital		PPS	
		w/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period on/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	10,520,914	3,801,322	14,322,236	19.00
		w/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	875,199	0	639,606	235,593	875,199	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,676	0	3,714	2,962	6,676	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0980	0.0980	0.0980	0.0980		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	85,770	0	62,682	23,088	85,770	25.00
26.00	Total prospective capital payments (see instructions)	12.00	967,645	0	706,002	261,643	967,645	26.00
		w/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.97					0	29.00
100.00	Transfer low volume adjustments to wkst. E, Pt. A.		Y					100.00

		Title XVIII			Hospital		PPS
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	7,900,879	7,900,879		7,900,879	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,892,567		2,892,567	2,892,567	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	177,056	107,707	69,349	177,056	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2731	0.2731	0.2731		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	736,923	539,433	197,490	736,923	11.00
11.01	Uncompensated care payments	36.00	1,647,166	1,266,893	380,273	1,647,166	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,354,591	9,814,912	3,539,679	13,354,591	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	13,354,591	9,814,912	3,539,679	13,354,591	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	967,645	706,002	261,643	967,645	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			10,520,914	3,801,322	14,322,236	19.00

		Title XVIII				Hospital	PPS
		wkst. L, line	(Amt. from wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	875,199	639,606	235,593	875,199	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,676	3,714	2,962	6,676	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0980	0.0980	0.0980	0	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	85,770	62,682	23,088	85,770	25.00
26.00	Total prospective capital payments (see instructions)	12.00	967,645	706,002	261,643	967,645	26.00
		wkst. E, Pt. A, line	(Amt. from wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00		70.96	0	0		0	27.00
28.00	Low volume adjustment prior to October 1	70.97	0	0	0	0	28.00
29.00	Low volume adjustment on or after October 1	70.93	-6,866	-12,009	5,143	-6,866	29.00
30.00	HVBP payment adjustment (see instructions)	70.90	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.94	-42,072	-33,973	-8,099	-42,072	30.01
31.00	HRR adjustment (see instructions)	70.91	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)						
						(Amt. to wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0292

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

Worksheet E
Part B
Date/Time Prepared:
5/29/2018 9:38 am

		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			12,021	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			3,825,618	2.00
3.00	OPPS payments			2,926,538	3.00
4.00	Outlier payment (see instructions)			11,079	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			12,021	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			46,282	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)			46,282	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 chargebasis 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)			46,282	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			34,261	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			12,021	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			2,937,617	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)			550,665	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)			2,398,973	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)			2,398,973	30.00
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)			2,398,973	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)			60,645	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			39,419	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			45,482	36.00
37.00	Subtotal (see instructions)			2,438,392	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			2,438,392	40.00
40.01	Sequestration adjustment (see instructions)			48,768	40.01
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
41.00	Interim payments			2,437,188	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			-47,564	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

Health Financial Systems	ADVENTIST GLENOAKS HOSPITAL	In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0292	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 9:38 am
	Title XVIII	Hospital	PPS
			overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2018 9:38 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		13,081,924		2,466,991	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			0		0	3.01
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	10/23/2017	116,492	10/23/2017	29,803	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)		-116,492		-29,803	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)		12,965,432		2,437,188	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			0		0	5.01
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program			0		0	5.50
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)		0		0	6.00
6.01	SETTLEMENT TO PROVIDER		29,178		47,564	6.01
6.02	SETTLEMENT TO PROGRAM		12,936,254		2,389,624	6.02
7.00	Total Medicare program liability (see instructions)					7.00
			0	Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0292

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2018 9:38 am

Component CCN: 14-S292

Title XVIII

Subprovider -
IPF

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		2,502,594		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		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)		2,502,594		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		26,569		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,529,163		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: 14-0292

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

Worksheet E-1
Part II
Date/Time Prepared:
5/29/2018 9:38 am

Title XVIII		Hospital	PPS
			1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6, line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPSS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00
			overrides
			1.00
CONTRACTOR OVERRIDES			
108.00	Override of HIT payment		108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0292

Period:

Worksheet E-3

Component CCN: 14-S292

From 01/01/2017

Part II

To 12/31/2017

Date/Time Prepared:

5/29/2018 9:38 am

Title XVIII

Subprovider -
IPF

PPS

1.00

PART II - MEDICARE PART A SERVICES - IPF PPS

1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,729,944	1.00
2.00	Net IPF PPS Outlier Payments	3,550	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	12.123288	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,733,494	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,733,494	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,733,494	18.00
19.00	Deductibles	157,780	19.00
20.00	Subtotal (line 18 minus line 19)	2,575,714	20.00
21.00	Coinurance	22,043	21.00
22.00	Subtotal (line 20 minus line 21)	2,553,671	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	41,704	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	27,108	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	35,252	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,580,779	26.00
27.00	Direct graduate medical education payments (from wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,580,779	31.00
31.01	Sequestration adjustment (see instructions)	51,616	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,502,594	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	26,569	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	3,550	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

Provider CCN: 14-0292

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

Worksheet G

Date/Time Prepared:
5/29/2018 9:38 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	-6,862,537	0	0	0	1.00
2.00	Temporary investments	1,361	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	56,597,845	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-38,313,708	0	0	0	6.00
7.00	Inventory	2,011,622	0	0	0	7.00
8.00	Prepaid expenses	1,176,802	0	0	0	8.00
9.00	Other current assets	673	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	14,612,058	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,869,112	0	0	0	12.00
13.00	Land improvements	620,881	0	0	0	13.00
14.00	Accumulated depreciation	-217,637	0	0	0	14.00
15.00	Buildings	36,007,563	0	0	0	15.00
16.00	Accumulated depreciation	-17,242,966	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	7,829,909	0	0	0	19.00
20.00	Accumulated depreciation	-7,045,129	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	17,981,914	0	0	0	23.00
24.00	Accumulated depreciation	-15,632,071	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)	24,171,576	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	774,508	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	6,913,602	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,688,110	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	46,471,744	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,343,147	0	0	0	37.00
38.00	Salaries, wages, and fees payable	869,063	0	0	0	38.00
39.00	Payroll taxes payable	2,967,083	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	22,130,425	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,309,718	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	9,711,290	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,712,290	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	40,022,008	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	6,449,736	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	6,449,736	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	46,471,744	0	0	0	60.00

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	31,837,837		31,837,837	1.00
2.00	SUBPROVIDER - IPF	6,740,295		6,740,295	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	38,578,132		38,578,132	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,651,195		5,651,195	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)	5,651,195		5,651,195	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	44,229,327		44,229,327	17.00
18.00	Ancillary services	84,946,483	86,863,403	171,809,886	18.00
19.00	Outpatient services	10,992,482	35,055,493	46,047,975	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	MISC	800	0	800	27.00
27.01	PHARMACY	0	1,148,395	1,148,395	27.01
27.02	PHYSICIAN REVENUE	0	437,810	437,810	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	140,169,092	123,505,101	263,674,193	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		93,331,046		29.00
30.00	BAD DEBT	5,569,747			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)		5,569,747		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to wkst. G-3, line 4)		98,900,793		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0292

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

Worksheet G-3

Date/Time Prepared:
5/29/2018 9:38 am

		1.00	
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)	263,674,193	1.00
2.00	Less contractual allowances and discounts on patients' accounts	172,832,741	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,841,452	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)	98,900,793	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,059,341	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 REVENUE	8,744,415	24.00
25.00	Total other income (sum of lines 6-24)	8,744,415	25.00
26.00	Total (line 5 plus line 25)	685,074	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	685,074	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0292

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

Worksheet L
Parts I-III
Date/Time Prepared:
5/29/2018 9:38 am

		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		875,199	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,676	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)		68.01	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)		6.26	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		39.92	8.00
9.00	Sum of lines 7 and 8		46.18	9.00
10.00	Allowable disproportionate share percentage (see instructions)		9.80	10.00
11.00	Disproportionate share adjustment (see instructions)		85,770	11.00
12.00	Total prospective capital payments (see instructions)		967,645	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