

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: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet 5 Parts I-III Date/Time Prepared: 5/29/2018 8:33 am
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PART I - COST REPORT STATUS

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

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

6. Date Received:
7. Contractor No.
8. Initial Report for this Provider CCN
9. Final Report for this Provider CCN

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

Date: 5/29/2018 Time: 8:33 am

PART II - CERTIFICATION

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

CERTIFICATION BY 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 BOLINGBROOK HOSPITAL (14-0304) 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.

Encryption Information

ECR: Date: 5/29/2018 Time: 8:33 am
98mxJJSH01X9otPPzf1EagigH.4vt0
IUCOB0E4808djgFM41y2TqWHENJi:0
rkUo143ywa0Rjff0
PI: Date: 5/29/2018 Time: 8:33 am
n658iRyzA58pv1NXC9zmYay1jxp0L0
qq9GK0gppuM3.RZjnqEfwcqn1cJThdy
xg180eYNmp0mt1rh

(Signed)

Officer or Administrator of Provider(s)

Title

Date

[Handwritten Signature]
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	-12,438	-63,977	0	0	1.00
2.00 Subprovider - IPF	0	0	-386		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	-12,438	-64,363	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:16 am
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	1.00	2.00	3.00	4.00	
Hospital and Hospital Health Care Complex Address:					
1.00	Street: 500 REMINGTON BLVD		PO Box:		1.00
2.00	City: BOLINGBROOK		State: IL	Zip Code: 60440- County: WILL	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 BOLINGBROOK HOSPITAL	140304	16974	1	01/13/2008	N	P	O	3.00
4.00	Subprovider - IPF	ADVENTIST BOLINGBROOK HOSPITAL PSYCH	145304	16974	4	01/01/2016	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.	899	1,267	7	30	4,120	179	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:16 am			
		Urban/Rural	S	Date of Geogr			
		1.00		2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0				35.00
		Beginning:		Ending:			
		1.00		2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
		Y/N		Y/N			
		1.00		2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N			40.00
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	Y	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 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N				60.00
		Y/N	IME	Direct GME	Direct GME		
		1.00	2.00	3.00	4.00 5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N	0.00 0.00			61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0304

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

Worksheet S-2
Part 1
Date/Time Prepared:
5/29/2018 8:16 am

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			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 beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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	
			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	N	0
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:16 am	
				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00	
				V 1.00	
				XIX 2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N	Y 90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	N 91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N 92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N	N 93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N	N 94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00 95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N	N 96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00 97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y	Y 98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N 109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete worksheet E, Part A, lines 200 through 218, and worksheet E-2, lines 200 through 215, as applicable.			N 110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:16 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:	1,638,611	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0304		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 8:16 am	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: ADVENTIST HEALTH SYSTEM	Contractor's Name: FIRST COAST SERVICE OPTIONS		Contractor's Number: 09001		141.00	
142.00	Street: 900 HOPE WAY	PO Box:				142.00	
143.00	City: ALTAMONTE SPRINGS	State: FL		Zip Code: 32714		143.00	
144.00 Are provider based physicians' costs included in worksheet A?							
						1.00	144.00
						Y	
145.00 If costs for renal services are claimed on wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							
						1.00	145.00
						Y	
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							
						2.00	146.00
						N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
						1.00	147.00
						N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
						1.00	148.00
						N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
						1.00	149.00
						N	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
		Part A		Part B		Title V	
		1.00		2.00		3.00	
		4.00		5.00		6.00	
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER	N		N		N	
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
165.00 Multicampus							
Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							
						1.00	165.00
						N	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
		Name		County		State	
		0		1.00		2.00	
		3.00		4.00		5.00	
		6.00		7.00		8.00	
		9.00		10.00		11.00	
		12.00		13.00		14.00	
		15.00		16.00		17.00	
		18.00		19.00		20.00	
		21.00		22.00		23.00	
		24.00		25.00		26.00	
		27.00		28.00		29.00	
		30.00		31.00		32.00	
		33.00		34.00		35.00	
		36.00		37.00		38.00	
		39.00		40.00		41.00	
		42.00		43.00		44.00	
		45.00		46.00		47.00	
		48.00		49.00		50.00	
		51.00		52.00		53.00	
		54.00		55.00		56.00	
		57.00		58.00		59.00	
		60.00		61.00		62.00	
		63.00		64.00		65.00	
		66.00		67.00		68.00	
		69.00		70.00		71.00	
		72.00		73.00		74.00	
		75.00		76.00		77.00	
		78.00		79.00		80.00	
		81.00		82.00		83.00	
		84.00		85.00		86.00	
		87.00		88.00		89.00	
		90.00		91.00		92.00	
		93.00		94.00		95.00	
		96.00		97.00		98.00	
		99.00		100.00		101.00	
		102.00		103.00		104.00	
		105.00		106.00		107.00	
		108.00		109.00		110.00	
		111.00		112.00		113.00	
		114.00		115.00		116.00	
		117.00		118.00		119.00	
		120.00		121.00		122.00	
		123.00		124.00		125.00	
		126.00		127.00		128.00	
		129.00		130.00		131.00	
		132.00		133.00		134.00	
		135.00		136.00		137.00	
		138.00		139.00		140.00	
		141.00		142.00		143.00	
		144.00		145.00		146.00	
		147.00		148.00		149.00	
		150.00		151.00		152.00	
		153.00		154.00		155.00	
		156.00		157.00		158.00	
		159.00		160.00		161.00	
		162.00		163.00		164.00	
		165.00		166.00		167.00	
		168.00		169.00		170.00	
		171.00		172.00		173.00	
		174.00		175.00		176.00	
		177.00		178.00		179.00	
		180.00		181.00		182.00	
		183.00		184.00		185.00	
		186.00		187.00		188.00	
		189.00		190.00		191.00	
		192.00		193.00		194.00	
		195.00		196.00		197.00	
		198.00		199.00		200.00	
		201.00		202.00		203.00	
		204.00		205.00		206.00	
		207.00		208.00		209.00	
		210.00		211.00		212.00	
		213.00		214.00		215.00	
		216.00		217.00		218.00	
		219.00		220.00		221.00	
		222.00		223.00		224.00	
		225.00		226.00		227.00	
		228.00		229.00		230.00	
		231.00		232.00		233.00	
		234.00		235.00		236.00	
		237.00		238.00		239.00	
		240.00		241.00		242.00	
		243.00		244.00		245.00	
		246.00		247.00		248.00	
		249.00		250.00		251.00	
		252.00		253.00		254.00	
		255.00		256.00		257.00	
		258.00		259.00		260.00	
		261.00		262.00		263.00	
		264.00		265.00		266.00	
		267.00		268.00		269.00	
		270.00		271.00		272.00	
		273.00		274.00		275.00	
		276.00		277.00		278.00	
		279.00		280.00		281.00	
		282.00		283.00		284.00	
		285.00		286.00		287.00	
		288.00		289.00		290.00	
		291.00		292.00		293.00	
		294.00		295.00		296.00	
		297.00		298.00		299.00	
		300.00		301.00		302.00	
		303.00		304.00		305.00	
		306.00		307.00		308.00	
		309.00		310.00		311.00	
		312.00		313.00		314.00	
		315.00		316.00		317.00	
		318.00		319.00		320.00	
		321.00		322.00		323.00	
		324.00		325.00		326.00	
		327.00		328.00		329.00	
		330.00		331.00		332.00	
		333.00		334.00		335.00	
		336.00		337.00		338.00	
		339.00		340.00		341.00	
		342.00		343.00		344.00	
		345.00		346.00		347.00	
		348.00		349.00		350.00	
		351.00		352.00		353.00	
		354.00		355.00		356.00	
		357.00		358.00		359.00	
		360.00		361.00		362.00	
		363.00		364.00		365.00	
		366.00		367.00		368.00	
		369.00		370.00		371.00	
		372.00		373.00		374.00	
		375.00		376.00		377.00	
		378.00		379.00		380.00	
		381.00		382.00		383.00	
		384.00		385.00		386.00	
		387.00		388.00		389.00	
		390.00		391.00		392.00	
		393.00		394.00		395.00	
		396.00		397.00		398.00	
		399.00		400.00		401.00	
		402.00		403.00		404.00	
		405.00		406.00		407.00	
		408.00		409.00		410.00	
		411.00		412.00		413.00	
		414.00		415.00		416.00	
		417.00		418.00		419.00	
		420.00		421.00		422.00	
		423.00		424.00		425.00	
		426.00		427.00		428.00	
		429.00		430.00		431.00	
		432.00		433.00		434.00	
		435.00		436.00		437.00	
		438.00		439.00		440.00	
		441.00		442.00		443.00	
		444.00		445.00		446.00	
		447.00		448.00		449.00	
		450.00		451.00		452.00	
		453.00		454.00		455.00	
		456.00		457.00		458.00	
		459.00		460.00		461.00	
		462.00		463.00		464.00	
		465.00		466.00		467.00	
		468.00		469.00		470.00	
		471.00		472.00		473.00	
		474.00		475.00		476.00	
		477.00		478.00		479.00	
		480.00		481.00		482.00	
		483.00		484.00		485.00	
		486.00		487.00		488.00	
		489.00		490.00		491.00	
		492.00		493.00		494.00	
		495.00		496.00		497.00	
		498.00		499.00		500.00	
		501.00		502.00		503.00	
		504.00		505.00		506.00	
		507.00		508.00		509.00	
		5					

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0304		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 8:16 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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 the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/01/2016	Y	04/01/2016		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been 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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0304

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

Worksheet S-2
Part II
Date/Time Prepared:
5/29/2018 8:16 am

		3.00	
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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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 14-0304

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

Worksheet S-2
Part V
Date/Time Prepared:
5/29/2018 8:16 am

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer		4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1		8.00
9.00	Mailing Address 2		9.00
10.00	City		10.00
11.00	State		11.00
12.00	Zip		12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	MIKE	13.00
14.00	Last Name	THOMPSON	14.00
15.00	Title	REIMBURSEMENT MANAGER	15.00
16.00	Employer	ADVENTIST HEALTH SYSTEM SUNBELT	16.00
17.00	Phone Number	(407) 357-2338	17.00
18.00	E-mail Address	MIKE.THOMPSON3@AHSS.ORG	18.00
19.00	Department	CORPORATE REIMBURSEMENT	19.00
20.00	Mailing Address 1	900 HOPE WAY	20.00
21.00	Mailing Address 2		21.00
22.00	City	ALTAMONTE SPRINGS	22.00
23.00	State	FL	23.00
24.00	Zip	32714	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 "0") 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	CAH Hours	I/P Days / O/P	Title V
	Line Number		Available		Visits / Trips	
	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	102	37,230	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		102	37,230	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	12	4,380	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)		114	41,610	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00 SUBPROVIDER - IRF						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)		138				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

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)	6,369	455	17,290			1.00
2.00 HMO and other (see instructions)	2,078	5,603				2.00
3.00 HMO IPF Subprovider	123	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)	6,369	455	17,290			7.00
8.00 INTENSIVE CARE UNIT	873	69	2,637			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		338	2,775			13.00
14.00 Total (see instructions)	7,242	862	22,702	0.00	744.09	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	3,588	14	4,392	0.00	43.21	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)	0	0	103			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	787.30	27.00
28.00 Observation Bed Days		131	3,620			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	37	175			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	1,793	458	6,044	1.00
2.00 HMO and other (see instructions)				485	1,285		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	1,793		458	6,044	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF	0.00	0	261		2	340	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: 14-0304	Period: From 01/01/2017 To 12/31/2017	worksheet S-3 Part II Date/Time Prepared: 5/29/2018 8:16 am			
	wkst. A Line Number	Amount Reported	Reclassification of Salaries (from wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	39,564,459	18,000	39,582,459	1,708,854.00	23.16	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		354,955	0	354,955	5,860.00	60.57	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,228,881	0	2,228,881	112,609.00	19.79	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		188,049	0	188,049	5,727.00	32.84	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		103,604	0	103,604	975.00	106.26	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		4,487,204	0	4,487,204	74,076.00	60.58	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)		7,291,694	0	7,291,694			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		477,290	0	477,290			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		1,210,833	0	1,210,833			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	942,678	18,000	960,678	2,114.00	454.44	26.00
27.00	Administrative & General	5.00	3,880,273	-154,799	3,725,474	87,226.00	42.71	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0304

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

Worksheet S-3
Part II
Date/Time Prepared:
5/29/2018 8:16 am

	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)	
wkst. A Line Number	2.00	3.00	4.00	5.00	6.00	
28.00 Administrative & General under contract (see inst.)	38,272	0	38,272	219.00	174.76	28.00
29.00 Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00 Operation of Plant	1,395,356	0	1,395,356	86,145.00	16.20	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	108,033.00	20.35	33.00
34.00 Dietary	778	0	778	21.00	37.05	34.00
35.00 Dietary under contract (see instructions)	1,191,722	0	1,191,722	53,561.00	22.25	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	775,483	154,799	930,282	27,057.00	34.38	38.00
39.00 Central Services and Supply	248,346	0	248,346	20,236.00	12.27	39.00
40.00 Pharmacy	1,612,797	0	1,612,797	49,449.00	32.62	40.00
41.00 Medical Records & Medical Records Library	297,806	0	297,806	16,937.00	17.58	41.00
42.00 Social Service	703,355	0	703,355	19,889.00	35.36	42.00
43.00 Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0304

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

Worksheet S-3
Part III
Date/Time Prepared:
5/29/2018 8:16 am

	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)	42,637,973	18,000	42,655,973	1,864,807.00	22.87	1.00
2.00	Excluded area salaries (see instructions)	2,228,881	0	2,228,881	112,609.00	19.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)	40,409,092	18,000	40,427,092	1,752,198.00	23.07	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,778,857	0	4,778,857	80,778.00	59.16	4.00
5.00	Subtotal wage-related costs (see inst.)	8,502,527	0	8,502,527	0.00	21.03	5.00
6.00	Total (sum of lines 3 thru 5)	53,690,476	18,000	53,708,476	1,832,976.00	29.30	6.00
7.00	Total overhead cost (see instructions)	13,285,341	18,000	13,303,341	470,887.00	28.25	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0304

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

worksheet S-3
Part IV
Date/Time Prepared:
5/29/2018 8:16 am

		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	975,859	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)	3,463,230	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)	61,846	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	355,850	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	2,767,640	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	36,185	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	108,373	23.00
24.00	Total wage Related cost (Sum of lines 1 -23)	7,768,983	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: 14-0304

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

Worksheet S-3
Part V
Date/Time Prepared:
5/29/2018 8:16 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	188,049	7,768,983	1.00
2.00	Hospital	188,049	7,768,983	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			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

		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)	0.215889	1.00	
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	12,387,260	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	106,341,552	6.00	
7.00	Medicaid cost (line 1 times line 6)	22,957,971	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)	10,570,711	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	33,115	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	10,570,711	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)	6,813,341	27,415	6,840,756
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,470,925	27,415	1,498,340
22.00	Payments received from patients for amounts previously written off as charity care	14,230	0	14,230
23.00	Cost of charity care (line 21 minus line 22)	1,456,695	27,415	1,484,110
				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)	8,160,270		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	324,146		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	498,687		27.01
28.00	Non-Medicare bad debt expense (see instructions)	7,661,583		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,828,592		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,312,702		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	13,883,413		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0304

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

worksheet A

Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	6,691,131	6,691,131	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	4,358,009	4,358,009	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	942,678	4,314,266	5,256,944	0	5,256,944	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,880,273	27,109,268	30,989,541	-228,906	30,760,635	5.00
7.00	00700	OPERATION OF PLANT	1,395,356	3,435,263	4,830,619	-6,953	4,823,666	7.00
9.00	00900	HOUSEKEEPING	0	2,794,363	2,794,363	-4,255	2,790,108	9.00
10.00	01000	DIETARY	778	2,026,968	2,027,746	-1,440,010	587,736	10.00
11.00	01100	CAFETERIA	0	0	0	1,439,950	1,439,950	11.00
13.00	01300	NURSING ADMINISTRATION	775,483	458,218	1,233,701	225,796	1,459,497	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	248,346	572,588	820,934	-456,932	364,002	14.00
15.00	01500	PHARMACY	1,612,797	7,430,209	9,043,006	-7,173,623	1,869,383	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	297,806	62,476	360,282	-120	360,162	16.00
17.00	01700	SOCIAL SERVICE	703,355	127,125	830,480	-1,036	829,444	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,688,348	1,353,721	9,042,069	-1,137,652	7,904,417	30.00
31.00	03100	INTENSIVE CARE UNIT	2,171,166	1,014,266	3,185,432	-270,795	2,914,637	31.00
40.00	04000	SUBPROVIDER - IPF	1,654,215	201,616	1,855,831	-15,969	1,839,862	40.00
43.00	04300	NURSERY	0	31,163	31,163	1,249,891	1,281,054	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,485,955	8,869,582	12,355,537	-6,086,425	6,269,112	50.00
51.00	05100	RECOVERY ROOM	622,154	69,160	691,314	-13,302	678,012	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,981,722	858,553	2,840,275	-661,677	2,178,598	52.00
53.00	05300	ANESTHESIOLOGY	51,492	297,437	348,929	-211,982	136,947	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,225,131	1,281,340	3,506,471	-630,419	2,876,052	54.00
56.00	05600	RADIOISOTOPE	165,676	60,617	226,293	-42,984	183,309	56.00
57.00	05700	CT SCAN	479,820	236,796	716,616	-57,007	659,609	57.00
58.00	05800	MRI	229,445	45,282	274,727	-2,470	272,257	58.00
59.00	05900	CARDIAC CATHETERIZATION	514,585	989,560	1,504,145	-845,524	658,621	59.00
60.00	06000	LABORATORY	1,768,808	2,634,318	4,403,126	-1,161,076	3,242,050	60.00
65.00	06500	RESPIRATORY THERAPY	794,603	303,943	1,098,546	-111,750	986,796	65.00
66.00	06600	PHYSICAL THERAPY	398	4,518,795	4,519,193	-404,623	4,114,570	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	50,754	50,754	0	50,754	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,978	15,978	-20	15,958	68.00
69.00	06900	ELECTROCARDIOLOGY	523,885	283,576	807,461	-8,844	798,617	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,519	419,751	449,270	-740	448,530	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	673,752	673,752	5,224,843	5,898,595	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	845,165	845,165	4,732,296	5,577,461	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,013,384	7,013,384	73.00
74.00	07400	RENAL DIALYSIS	0	429,084	429,084	0	429,084	74.00
76.00	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	466	32,687	33,153	-28,994	4,159	76.01
76.97	07697	CARDIAC REHABILITATION	127,424	17,502	144,926	-1,473	143,453	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	935,970	359,456	1,295,426	-174,568	1,120,858	90.00
91.00	09100	EMERGENCY	3,682,139	1,519,413	5,201,552	-515,663	4,685,889	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		9,302,147	9,302,147	-9,239,508	62,639	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,989,793	85,046,158	124,035,951	0	124,035,951	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	92,988	41,586	134,574	0	134,574	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,702,145	2,702,145	0	2,702,145	192.00
194.00	07950	FOUNDATION	148,518	26,186	174,704	0	174,704	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	78,875	78,875	0	78,875	194.02
194.03	07953	OP PHARMACY	219,240	474,367	693,607	0	693,607	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	113,920	136,630	250,550	0	250,550	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	39,564,459	88,505,947	128,070,406	0	128,070,406	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0304

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

Worksheet A

Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-328,069	6,363,062	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	24,661	4,382,670	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-126,467	5,130,477	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,106,663	22,653,972	5.00
7.00	00700	OPERATION OF PLANT	-30,288	4,793,378	7.00
9.00	00900	HOUSEKEEPING	0	2,790,108	9.00
10.00	01000	DIETARY	-522,587	65,149	10.00
11.00	01100	CAFETERIA	0	1,439,950	11.00
13.00	01300	NURSING ADMINISTRATION	-8,067	1,451,430	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	364,002	14.00
15.00	01500	PHARMACY	-319	1,869,064	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,270	426,432	16.00
17.00	01700	SOCIAL SERVICE	0	829,444	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-98,679	7,805,738	30.00
31.00	03100	INTENSIVE CARE UNIT	-8,309	2,906,328	31.00
40.00	04000	SUBPROVIDER - IPF	0	1,839,862	40.00
43.00	04300	NURSERY	-1,440	1,279,614	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-588,212	5,680,900	50.00
51.00	05100	RECOVERY ROOM	-46	677,966	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-406,840	1,771,758	52.00
53.00	05300	ANESTHESIOLOGY	0	136,947	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-106,424	2,769,628	54.00
56.00	05600	RADIOISOTOPE	0	183,309	56.00
57.00	05700	CT SCAN	0	659,609	57.00
58.00	05800	MRI	0	272,257	58.00
59.00	05900	CARDIAC CATHETERIZATION	-26,163	632,458	59.00
60.00	06000	LABORATORY	-2,093	3,239,957	60.00
65.00	06500	RESPIRATORY THERAPY	-3,159	983,637	65.00
66.00	06600	PHYSICAL THERAPY	-606	4,113,964	66.00
67.00	06700	OCCUPATIONAL THERAPY	-126	50,628	67.00
68.00	06800	SPEECH PATHOLOGY	-176	15,782	68.00
69.00	06900	ELECTROCARDIOLOGY	-208,585	590,032	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-150,100	298,430	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-344	5,898,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,577,461	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-24,031	6,989,353	73.00
74.00	07400	RENAL DIALYSIS	-2,457	426,627	74.00
76.00	03020	ANCILLARY	0	0	76.00
76.01	03950	WOUND CARE	0	4,159	76.01
76.97	07697	CARDIAC REHABILITATION	-8,380	135,073	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-48,577	1,072,281	90.00
91.00	09100	EMERGENCY	-469,503	4,216,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-62,639	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,248,418	112,787,533	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	134,574	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,702,145	192.00
194.00	07950	FOUNDATION	0	174,704	194.00
194.01	07951	MARKETING	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	78,875	194.02
194.03	07953	OP PHARMACY	0	693,607	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	250,550	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,248,418	116,821,988	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0304

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

Worksheet Non-CMS W

Date/Time Prepared:
5/29/2018 8:16 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
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
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	ANCILLARY	03020	ACUPUNCTURE	76.00
76.01	WOUND CARE	03950		76.01
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
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
194.00	FOUNDATION	07950		194.00
194.01	MARKETING	07951		194.01
194.02	PROF OFFICE BUILDINGS	07952		194.02
194.03	OP PHARMACY	07953		194.03
194.04	OTHER NONREIMBURSABLE COST CENTERS	07954		194.04
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	0	1,439,950	1.00
	0			1,439,950	
B - NURSERY					
1.00	NURSERY	43.00	1,007,652	264,304	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	56,159	2.00
	0		1,007,652	320,463	
C - PROPERTY					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	60,844	1.00
	0			60,844	
D - CNO					
1.00	NURSING ADMINISTRATION	13.00	154,799	71,517	1.00
	0		154,799	71,517	
E - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	908,287	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,446,523	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	209,603	3.00
	0			2,564,413	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,617,500	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,049,464	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
	0			6,666,964	
H - BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,233,412	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
	0			5,233,412	
I - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,013,384	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	7,013,384	
J - RENT AND LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	955,950	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	857,222	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,807	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
	0		0	1,814,979	
K - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,550	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,800	2.00
	0		0	153,350	
L - IMPLANTIBLES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,740,976	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	4,740,976	
M - HEP C CLINIC					
1.00	CLINIC	90.00	160	9,173	1.00
	TOTALS		160	9,173	
N - RECRUITMENT BONUS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,000	0	1.00
	TOTALS		18,000	0	
500.00	Grand Total: Increases		1,180,611	30,089,425	500.00

RECLASSIFICATIONS

Provider CCN: 14-0304

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

Worksheet A-6

Date/Time Prepared:
5/29/2018 8:16 am

		Decreases			wkst. A-7 Ref.	
Cost Center	Line #	Salary	Other			
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00	DIETARY	10.00	0	1,439,950	0	1.00
	0		0	1,439,950		
B - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	861,015	0	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	146,637	320,463	0	2.00
	0		1,007,652	320,463		
C - PROPERTY						
1.00	INTEREST EXPENSE	113.00	0	60,844	13	1.00
	0		0	60,844		
D - CNO						
1.00	ADMINISTRATIVE & GENERAL	5.00	154,799	71,517	0	1.00
	0		154,799	71,517		
E - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	2,564,413	11	1.00
2.00		0.00	0	0	11	2.00
3.00		0.00	0	0	0	3.00
	0		0	2,564,413		
F - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,540	9	1.00
2.00	OPERATION OF PLANT	7.00	0	6,213	9	2.00
3.00	OPERATING ROOM	50.00	0	14,163	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	833	0	4.00
5.00	LABORATORY	60.00	0	1,218	0	5.00
6.00	RESPIRATORY THERAPY	65.00	0	579	0	6.00
7.00	ELECTROCARDIOLOGY	69.00	0	3,167	0	7.00
8.00	INTEREST EXPENSE	113.00	0	6,614,251	0	8.00
	0		0	6,666,964		
H - BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	320,393	0	1.00
2.00	PHARMACY	15.00	0	60,340	0	2.00
3.00	SOCIAL SERVICE	17.00	0	316	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	309,977	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	265,991	0	5.00
6.00	SUBPROVIDER - IPF	40.00	0	15,969	0	6.00
7.00	NURSERY	43.00	0	22,001	0	7.00
8.00	OPERATING ROOM	50.00	0	1,563,289	0	8.00
9.00	RECOVERY ROOM	51.00	0	13,283	0	9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	191,586	0	10.00
11.00	ANESTHESIOLOGY	53.00	0	84,090	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	63,442	0	12.00
13.00	RADIOISOTOPE	56.00	0	42,984	0	13.00
14.00	CT SCAN	57.00	0	56,907	0	14.00
15.00	MRI	58.00	0	2,290	0	15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	542,244	0	16.00
17.00	LABORATORY	60.00	0	1,002,444	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	98,630	0	18.00
19.00	PHYSICAL THERAPY	66.00	0	1,552	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	5,354	0	20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	720	0	21.00
22.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,680	0	22.00
23.00	WOUND CARE	76.01	0	1,178	0	23.00
24.00	CARDIAC REHABILITATION	76.97	0	1,473	0	24.00
25.00	CLINIC	90.00	0	48,266	0	25.00
26.00	EMERGENCY	91.00	0	510,013	0	26.00
	0		0	5,233,412		
I - DRUGS CHARGED TO PATIENTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,326	0	1.00
2.00	PHARMACY	15.00	0	6,852,712	0	2.00
3.00	SOCIAL SERVICE	17.00	0	600	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	469	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	591	0	5.00
6.00	NURSERY	43.00	0	64	0	6.00
7.00	OPERATING ROOM	50.00	0	10,215	0	7.00
8.00	RECOVERY ROOM	51.00	0	19	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	680	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	127,072	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	562	0	11.00
12.00	CT SCAN	57.00	0	100	0	12.00
13.00	MRI	58.00	0	100	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	68	0	14.00
15.00	LABORATORY	60.00	0	19	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	3	0	16.00

		Decreases					
	Cost Center	Line #	Salary	Other	10.00	10.00	
	6.00	7.00	8.00	9.00			
17.00	CLINIC	90.00	0	2,936	0		17.00
18.00	EMERGENCY	91.00	0	848	0		18.00
	0		0	7,013,384			
J - RENT AND LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,303	10		1.00
2.00	OPERATION OF PLANT	7.00	0	740	10		2.00
3.00	HOUSEKEEPING	9.00	0	4,255	0		3.00
4.00	DIETARY	10.00	0	60	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	520	0		5.00
6.00	PHARMACY	15.00	0	260,571	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	120	0		7.00
8.00	SOCIAL SERVICE	17.00	0	120	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	21,531	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	3,903	0		10.00
11.00	OPERATING ROOM	50.00	0	229,017	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,098	0		12.00
13.00	ANESTHESIOLOGY	53.00	0	820	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	565,582	0		14.00
15.00	MRI	58.00	0	80	0		15.00
16.00	CARDIAC CATHETERIZATION	59.00	0	1,735	0		16.00
17.00	LABORATORY	60.00	0	157,395	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	12,541	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	403,071	0		19.00
20.00	SPEECH PATHOLOGY	68.00	0	20	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	320	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	20	0		22.00
23.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	58	0		23.00
24.00	CLINIC	90.00	0	117,754	0		24.00
25.00	EMERGENCY	91.00	0	345	0		25.00
	0		0	1,814,979			
K - INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	153,350	12		1.00
2.00		0.00	0	0	12		2.00
	0		0	153,350			
L - IMPLANTIBLES							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	122,020	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	819	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	310	0		3.00
4.00	OPERATING ROOM	50.00	0	4,269,741	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	0	213	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	301,477	0		6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,511	0		7.00
8.00	WOUND CARE	76.01	0	18,483	0		8.00
9.00	CLINIC	90.00	0	14,945	0		9.00
10.00	EMERGENCY	91.00	0	4,457	0		10.00
	0		0	4,740,976			
M - HEP C CLINIC							
1.00	WOUND CARE	76.01	160	9,173	0		1.00
	TOTALS		160	9,173			
N - RECRUITMENT BONUS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18,000	0		1.00
	TOTALS		0	18,000			
500.00	Grand Total: Decreases		1,162,611	30,107,425			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 - CAFETERIA									
1.00	CAFETERIA	11.00	0	1,439,950	DIETARY	10.00	0	1,439,950	1.00
	0		0	1,439,950	0		0	1,439,950	
B - NURSERY									
1.00	NURSERY	43.00	1,007,652	264,304	ADULTS & PEDIATRICS	30.00	861,015	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	56,159	DELIVERY ROOM & LABOR ROOM	52.00	146,637	320,463	2.00
	0		1,007,652	320,463	0		1,007,652	320,463	
C - PROPERTY									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	60,844	INTEREST EXPENSE	113.00	0	60,844	1.00
	0		0	60,844	0		0	60,844	
D - CNO									
1.00	NURSING ADMINISTRATION	13.00	154,799	71,517	ADMINISTRATIVE & GENERAL	5.00	154,799	71,517	1.00
	0		154,799	71,517	0		154,799	71,517	
E - INTEREST RECLASS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	908,287	INTEREST EXPENSE	113.00	0	2,564,413	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,446,523		0.00	0	0	2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	209,603		0.00	0	0	3.00
	0		0	2,564,413	0		0	2,564,413	
F - DEPRECIATION									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,617,500	ADMINISTRATIVE & GENERAL	5.00	0	26,540	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,049,464	OPERATION OF PLANT	7.00	0	6,213	2.00
3.00		0.00	0	0	OPERATING ROOM	50.00	0	14,163	3.00
4.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	833	4.00
5.00		0.00	0	0	LABORATORY	60.00	0	1,218	5.00
6.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	579	6.00
7.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	3,167	7.00
8.00		0.00	0	0	INTEREST EXPENSE	113.00	0	6,614,251	8.00
	0		0	6,666,964	0		0	6,666,964	
H - BILLABLE SUPPLIES									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,233,412	CENTRAL SERVICES & SUPPLY	14.00	0	320,393	1.00
2.00		0.00	0	0	PHARMACY	15.00	0	60,340	2.00
3.00		0.00	0	0	SOCIAL SERVICE	17.00	0	316	3.00
4.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	309,977	4.00
5.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	265,991	5.00
6.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	15,969	6.00
7.00		0.00	0	0	NURSERY	43.00	0	22,001	7.00
8.00		0.00	0	0	OPERATING ROOM	50.00	0	1,563,289	8.00
9.00		0.00	0	0	RECOVERY ROOM	51.00	0	13,283	9.00
10.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	191,586	10.00
11.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	84,090	11.00
12.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	63,442	12.00
13.00		0.00	0	0	RADIOISOTOPE	56.00	0	42,984	13.00
14.00		0.00	0	0	CT SCAN	57.00	0	56,907	14.00
15.00		0.00	0	0	MRI	58.00	0	2,290	15.00
16.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	542,244	16.00
17.00		0.00	0	0	LABORATORY	60.00	0	1,002,444	17.00
18.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	98,630	18.00
19.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	1,552	19.00
20.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	5,354	20.00
21.00		0.00	0	0	ELECTROENCEPHALOGRAPHY	70.00	0	720	21.00
22.00		0.00	0	0	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	8,680	22.00
23.00		0.00	0	0	WOUND CARE	76.01	0	1,178	23.00
24.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	1,473	24.00
25.00		0.00	0	0	CLINIC	90.00	0	48,266	25.00
26.00		0.00	0	0	EMERGENCY	91.00	0	510,013	26.00
	0		0	5,233,412	0		0	5,233,412	
I - DRUGS CHARGED TO PATIENTS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,013,384	CENTRAL SERVICES & SUPPLY	14.00	0	16,326	1.00
2.00		0.00	0	0	PHARMACY	15.00	0	6,852,712	2.00
3.00		0.00	0	0	SOCIAL SERVICE	17.00	0	600	3.00

	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	
4.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	469	4.00
5.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	591	5.00
6.00		0.00	0	0	NURSERY	43.00	0	64	6.00
7.00		0.00	0	0	OPERATING ROOM	50.00	0	10,215	7.00
8.00		0.00	0	0	RECOVERY ROOM	51.00	0	19	8.00
9.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	680	9.00
10.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	127,072	10.00
11.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	562	11.00
12.00		0.00	0	0	CT SCAN	57.00	0	100	12.00
13.00		0.00	0	0	MRI	58.00	0	100	13.00
14.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	68	14.00
15.00		0.00	0	0	LABORATORY	60.00	0	19	15.00
16.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	3	16.00
17.00		0.00	0	0	CLINIC	90.00	0	2,936	17.00
18.00		0.00	0	0	EMERGENCY	91.00	0	848	18.00
0			0	7,013,384			0	7,013,384	
J - RENT AND LEASES									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	955,950	ADMINISTRATIVE & GENERAL	5.00	0	32,303	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	857,222	OPERATION OF PLANT	7.00	0	740	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,807	HOUSEKEEPING	9.00	0	4,255	3.00
4.00		0.00	0	0	DIETARY	10.00	0	60	4.00
5.00		0.00	0	0	NURSING ADMINISTRATION	13.00	0	520	5.00
6.00		0.00	0	0	PHARMACY	15.00	0	260,571	6.00
7.00		0.00	0	0	MEDICAL RECORDS & LIBRARY	16.00	0	120	7.00
8.00		0.00	0	0	SOCIAL SERVICE	17.00	0	120	8.00
9.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	21,531	9.00
10.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	3,903	10.00
11.00		0.00	0	0	OPERATING ROOM	50.00	0	229,017	11.00
12.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	2,098	12.00
13.00		0.00	0	0	ANESTHESIOLOGY	53.00	0	820	13.00
14.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	565,582	14.00
15.00		0.00	0	0	MRI	58.00	0	80	15.00
16.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	1,735	16.00
17.00		0.00	0	0	LABORATORY	60.00	0	157,395	17.00
18.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	12,541	18.00
19.00		0.00	0	0	PHYSICAL THERAPY	66.00	0	403,071	19.00
20.00		0.00	0	0	SPEECH PATHOLOGY	68.00	0	20	20.00
21.00		0.00	0	0	ELECTROCARDIOLOGY	69.00	0	320	21.00
22.00		0.00	0	0	ELECTROENCEPHALOGRAPH Y	70.00	0	20	22.00
23.00		0.00	0	0	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	58	23.00
24.00		0.00	0	0	CLINIC	90.00	0	117,754	24.00
25.00		0.00	0	0	EMERGENCY	91.00	0	345	25.00
0			0	1,814,979			0	1,814,979	
K - INSURANCE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	148,550	ADMINISTRATIVE & GENERAL	5.00	0	153,350	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,800		0.00	0	0	2.00
0			0	153,350			0	153,350	
L - IMPLANTIBLES									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,740,976	CENTRAL SERVICES & SUPPLY	14.00	0	122,020	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	819	2.00
3.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	310	3.00
4.00		0.00	0	0	OPERATING ROOM	50.00	0	4,269,741	4.00
5.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	213	5.00
6.00		0.00	0	0	CARDIAC CATHETERIZATION	59.00	0	301,477	6.00
7.00		0.00	0	0	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,511	7.00
8.00		0.00	0	0	WOUND CARE	76.01	0	18,483	8.00
9.00		0.00	0	0	CLINIC	90.00	0	14,945	9.00
10.00		0.00	0	0	EMERGENCY	91.00	0	4,457	10.00

	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	
	0		0	4,740,976	0		0	4,740,976	
	M - HEP C CLINIC								
1.00	CLINIC	90.00	160	9,173	WOUND CARE	76.01	160	9,173	1.00
	TOTALS		160	9,173	TOTALS		160	9,173	
	N - RECRUITMENT BONUS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	18,000	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18,000	1.00
	TOTALS		18,000	0	TOTALS		0	18,000	
500.00	Grand Total:		1,180,611	30,089,425	Grand Total:		1,162,611	30,107,425	500.00
	Increases				Decreases				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0304

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

Worksheet A-7
Part I
Date/Time Prepared:
5/29/2018 8:16 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	5,440,226	0	0	0	1,690,226	1.00
2.00 Land Improvements	84,552	227,483	0	227,483	0	2.00
3.00 Buildings and Fixtures	111,966,702	0	0	0	0	3.00
4.00 Building Improvements	0	0	0	0	0	4.00
5.00 Fixed Equipment	23,136,181	0	0	0	0	5.00
6.00 Movable Equipment	40,440,398	327,810	0	327,810	0	6.00
7.00 HIT designated Assets	0	0	0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	181,068,059	555,293	0	555,293	1,690,226	8.00
9.00 Reconciling Items	0	0	0	0	0	9.00
10.00 Total (line 8 minus line 9)	181,068,059	555,293	0	555,293	1,690,226	10.00
	Ending Balance	Fully Depreciated Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00 Land	3,750,000	0				1.00
2.00 Land Improvements	312,035	0				2.00
3.00 Buildings and Fixtures	111,966,702	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	23,136,181	0				5.00
6.00 Movable Equipment	40,768,208	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	179,933,126	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	179,933,126	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0304

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

Worksheet A-7
Part II
Date/Time Prepared:
5/29/2018 8:16 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: 14-0304

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

Worksheet A-7
Part III
Date/Time Prepared:
5/29/2018 8:16 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	139,164,918	0	139,164,918	0.773426	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	40,768,208	0	40,768,208	0.226574	0	2.00
3.00	Total (sum of lines 1-2)	179,933,126	0	179,933,126	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,457,214	955,950	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,049,464	857,222	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,506,678	1,813,172	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	801,348	148,550	0	0	6,363,062	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,471,184	4,800	0	0	4,382,670	2.00
3.00	Total (sum of lines 1-2)	2,272,532	153,350	0	0	10,745,732	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-235,874	CAP REL COSTS-BLDG & FIXT	1.00		11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-375,649	CAP REL COSTS-MVBLE EQUIP	2.00		11	2.00
3.00 Investment income - other (chapter 2)	B	-54,432	ADMINISTRATIVE & GENERAL	5.00		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	-49,224	ADMINISTRATIVE & GENERAL	5.00		0	7.00
8.00 Television and radio service (chapter 21)	A	-25,113	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	-547,025				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	683,649				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	0	DIETARY	10.00		0	14.00
15.00 Rental of quarters to employee and others		0		0.00		0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00		0	16.00
17.00 Sale of drugs to other than patients		0		0.00		0	17.00
18.00 Sale of medical records and abstracts	B	0	MEDICAL RECORDS & LIBRARY	16.00		0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.00
19.01 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00		0	19.01
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

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0304

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

Worksheet A-8

Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From Which the Amount is to be Adjusted				wkst. A-7 Ref.
			Cost Center		Line #	5.00	
			3.00	4.00	5.00		
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00	
33.00 COLLECTION FEES	A	-21,707	ADMINISTRATIVE & GENERAL		5.00	0 33.00	
33.01 OTHER REVENUE	B	-954,040	ADMINISTRATIVE & GENERAL		5.00	0 33.01	
33.02 OTHER REVENUE	B	-160,286	CAP REL COSTS-BLDG & FIXT		1.00	9 33.02	
33.03 OTHER REVENUE	B	-5,175	OPERATION OF PLANT		7.00	0 33.03	
33.04 OTHER REVENUE	B	-522,587	DIETARY		10.00	0 33.04	
33.05 OTHER REVENUE	B	-12,000	EMERGENCY		91.00	0 33.05	
33.06 OTHER REVENUE	B	-6,500	NURSING ADMINISTRATION		13.00	0 33.06	
33.07 OTHER REVENUE	B	-840	MEDICAL RECORDS & LIBRARY		16.00	0 33.07	
33.08 OTHER REVENUE	B	-1,500	OPERATING ROOM		50.00	0 33.08	
33.09 OTHER REVENUE	B	-11,330	DELIVERY ROOM & LABOR ROOM		52.00	0 33.09	
33.10 OTHER REVENUE	B	-8,372	RADIOLOGY-DIAGNOSTIC		54.00	0 33.10	
33.11 OTHER REVENUE	B	-26,163	CARDIAC CATHETERIZATION		59.00	0 33.11	
33.12 OTHER REVENUE	B	-10,228	DRUGS CHARGED TO PATIENTS		73.00	0 33.12	
33.13 OTHER REVENUE	B	-8,380	CARDIAC REHABILITATION		76.97	0 33.13	
33.14 OTHER REVENUE	B	-46,145	CLINIC		90.00	0 33.14	
33.15 STATE ASSESSMENT	A	-4,686,881	ADMINISTRATIVE & GENERAL		5.00	0 33.15	
33.16 CHARITY AND COMMUNITY SERVICES	A	-8,500	ADMINISTRATIVE & GENERAL		5.00	0 33.16	
33.17 ENTERTAINMENT	A	-2,789	ADMINISTRATIVE & GENERAL		5.00	0 33.17	
33.18 ENTERTAINMENT	A	-289	PHARMACY		15.00	0 33.18	
33.19 MALPRACTICE	A	-1,638,611	ADMINISTRATIVE & GENERAL		5.00	0 33.19	
33.20 DUES & LOBBYING	A	-43,845	ADMINISTRATIVE & GENERAL		5.00	0 33.20	
33.21 DUES & LOBBYING	A	-1,567	NURSING ADMINISTRATION		13.00	0 33.21	
33.22 DUES & LOBBYING	A	-30	PHARMACY		15.00	0 33.22	
33.23 DUES & LOBBYING	A	-46	RECOVERY ROOM		51.00	0 33.23	
33.24 DUES & LOBBYING	A	-74	LABORATORY		60.00	0 33.24	
33.25 DUES & LOBBYING	A	-2,432	CLINIC		90.00	0 33.25	
33.26 ADVERTISING & MARKETING	A	-43,699	ADMINISTRATIVE & GENERAL		5.00	0 33.26	
33.27 ADVERTISING & MARKETING	A	-14	ADULTS & PEDIATRICS		30.00	0 33.27	
33.28 ADVERTISING & MARKETING	A	-1,440	NURSERY		43.00	0 33.28	
33.29 CORPORATE SPONSORSHIP	A	-1,500	ADMINISTRATIVE & GENERAL		5.00	0 33.29	
33.30 PROPERT TAXES	A	-60,844	CAP REL COSTS-BLDG & FIXT		1.00	13 33.30	
33.31 NON ALLOW PHYSICIAN FEES	A	-436,350	EMERGENCY		91.00	0 33.31	
33.32 NON ALLOW PHYSICIAN FEES	A	-4,700	ADMINISTRATIVE & GENERAL		5.00	0 33.32	
33.33 NON ALLOW PHYSICIAN FEES	A	-585,700	OPERATING ROOM		50.00	0 33.33	
33.34 NON ALLOW PHYSICIAN FEES	A	-395,510	DELIVERY ROOM & LABOR ROOM		52.00	0 33.34	
33.35 NON ALLOW PHYSICIAN FEES	A	-97,725	RADIOLOGY-DIAGNOSTIC		54.00	0 33.35	
33.36 NON ALLOW PHYSICIAN FEES	A	-208,029	ELECTROCARDIOLOGY		69.00	0 33.36	
33.37 NON ALLOW PHYSICIAN FEES	A	-144,100	ELECTROENCEPHALOGRAPHY		70.00	0 33.37	
33.38 HOSPICE	A	-1,012	OPERATING ROOM		50.00	0 33.38	
33.39 HOSPICE	A	-327	RADIOLOGY-DIAGNOSTIC		54.00	0 33.39	
33.40 HOSPICE	A	-2,019	LABORATORY		60.00	0 33.40	
33.41 HOSPICE	A	-3,159	RESPIRATORY THERAPY		65.00	0 33.41	
33.42 HOSPICE	A	-606	PHYSICAL THERAPY		66.00	0 33.42	
33.43 HOSPICE	A	-126	OCCUPATIONAL THERAPY		67.00	0 33.43	
33.44 HOSPICE	A	-176	SPEECH PATHOLOGY		68.00	0 33.44	
33.45 HOSPICE	A	-556	ELECTROCARDIOLOGY		69.00	0 33.45	
33.46 HOSPICE	A	-344	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	0 33.46	
33.47 HOSPICE	A	-13,803	DRUGS CHARGED TO PATIENTS		73.00	0 33.47	
33.48 HOSPICE	A	-2,457	RENAL DIALYSIS		74.00	0 33.48	
33.49 HOSPICE	A	-1,968	EMERGENCY		91.00	0 33.49	
33.50 HOSPICE	A	-98,665	ADULTS & PEDIATRICS		30.00	0 33.50	
33.51 HOSPICE	A	-8,309	INTENSIVE CARE UNIT		31.00	0 33.51	
33.52 SELF INSURED	A	-351,295	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.52	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-11,248,418				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: 14-0304

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

Worksheet A-8-1

Date/Time Prepared:
5/29/2018 8:16 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	128,935	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	400,310	0
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	251,213	26,385
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	6,891,847	6,966,742
3.02	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	67,110	0
4.00	113.00	INTEREST EXPENSE	HOME OFFICE	2,564,413	2,627,052
4.01	0.00			0	0
4.02	0.00			0	0
4.03	0.00			0	0
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			10,303,828	9,620,179

* 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	100.00	HOME OFFICE	0.00	6.00
7.00	B	HINSDALE HOSPIT	0.00	RELATED PARTY	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0304

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

worksheet A-8-1

Date/Time Prepared:
5/29/2018 8:16 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	128,935	11	1.00
2.00	400,310	11	2.00
3.00	224,828	9	3.00
3.01	-74,895	0	3.01
3.02	67,110	0	3.02
4.00	-62,639	0	4.00
4.01	0	0	4.01
4.02	0	0	4.02
4.03	0	0	4.03
5.00	683,649		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 SERVICES	6.00
7.00	FINANCIAL SERVICES	7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0304

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

worksheet A-8-2

Date/Time Prepared:
5/29/2018 8:16 am

	wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
29.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	521,840	521,840	0	0	0	29.00
30.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	6,000	6,000	0	0	0	30.00
31.00	91.00	AGGREGATE-EMERGENCY	19,185	19,185	0	0	0	31.00
200.00			547,025	547,025	0	0	0	200.00
	wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
29.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	0	0	29.00
30.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	0	0	30.00
31.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	31.00
200.00			0	0	0	0	0	200.00
	wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
29.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	0	0	521,840	0	29.00
30.00	70.00	AGGREGATE-ELECTROENCEPHALOGRAPHY	0	0	0	6,000	0	30.00
31.00	91.00	AGGREGATE-EMERGENCY	0	0	0	19,185	0	31.00
200.00			0	0	0	547,025	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	6,363,062	6,363,062			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	4,382,670		4,382,670		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,130,477	0	0	5,130,477	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,653,972	290,383	200,006	494,888	23,639,249 5.00
7.00 00700	OPERATION OF PLANT	4,793,378	400,167	275,622	185,358	5,654,525 7.00
9.00 00900	HOUSEKEEPING	2,790,108	36,653	25,246	0	2,852,007 9.00
10.00 01000	DIETARY	65,149	192,861	132,836	103	390,949 10.00
11.00 01100	CAFETERIA	1,439,950	71,918	49,534	0	1,561,402 11.00
13.00 01300	NURSING ADMINISTRATION	1,451,430	120,105	82,725	123,578	1,777,838 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	364,002	127,317	87,692	32,990	612,001 14.00
15.00 01500	PHARMACY	1,869,064	50,437	34,739	214,242	2,168,482 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	426,432	75,005	51,661	39,560	592,658 16.00
17.00 01700	SOCIAL SERVICE	829,444	15,901	10,952	93,433	949,730 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	7,805,738	1,257,728	866,284	906,935	10,836,685 30.00
31.00 03100	INTENSIVE CARE UNIT	2,906,328	260,743	179,591	288,416	3,635,078 31.00
40.00 04000	SUBPROVIDER - IPF	1,839,862	324,787	223,703	219,744	2,608,096 40.00
43.00 04300	NURSERY	1,279,614	79,394	54,684	133,855	1,547,547 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	5,680,900	803,488	553,416	463,071	7,500,875 50.00
51.00 05100	RECOVERY ROOM	677,966	78,423	54,016	82,646	893,051 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,771,758	279,577	192,563	243,771	2,487,669 52.00
53.00 05300	ANESTHESIOLOGY	136,947	13,740	9,463	6,840	166,990 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,769,628	524,374	361,172	295,584	3,950,758 54.00
56.00 05600	RADIOISOTOPE	183,309	161,081	110,948	22,008	477,346 56.00
57.00 05700	CT SCAN	659,609	28,846	19,868	63,739	772,062 57.00
58.00 05800	MRI	272,257	20,290	13,975	30,479	337,001 58.00
59.00 05900	CARDIAC CATHETERIZATION	632,458	24,811	17,089	68,357	742,715 59.00
60.00 06000	LABORATORY	3,239,957	87,488	60,259	234,967	3,622,671 60.00
65.00 06500	RESPIRATORY THERAPY	983,637	11,909	8,203	105,554	1,109,303 65.00
66.00 06600	PHYSICAL THERAPY	4,113,964	303,593	209,105	53	4,626,715 66.00
67.00 06700	OCCUPATIONAL THERAPY	50,628	21,039	14,491	0	86,158 67.00
68.00 06800	SPEECH PATHOLOGY	15,782	1,853	1,276	0	18,911 68.00
69.00 06900	ELECTROCARDIOLOGY	590,032	12,946	8,917	69,592	681,487 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	298,430	30,434	20,962	3,921	353,747 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,898,251	0	0	0	5,898,251 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	5,577,461	0	0	0	5,577,461 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	6,989,353	0	0	0	6,989,353 73.00
74.00 07400	RENAL DIALYSIS	426,627	0	0	0	426,627 74.00
76.00 03020	ANCILLARY	0	0	0	0	0 76.00
76.01 03950	WOUND CARE	4,159	28,670	19,747	41	52,617 76.01
76.97 07697	CARDIAC REHABILITATION	135,073	35,749	24,623	16,927	212,372 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	1,072,281	240,475	165,631	124,355	1,602,742 90.00
91.00 09100	EMERGENCY	4,216,386	323,133	222,563	489,132	5,251,214 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	112,787,533	6,335,318	4,363,562	5,054,139	112,664,343 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	134,574	18,128	12,486	12,352	177,540 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,702,145	0	0	0	2,702,145 192.00
194.00 07950	FOUNDATION	174,704	4,455	3,068	19,729	201,956 194.00
194.01 07951	MARKETING	0	0	0	0	0 194.01
194.02 07952	PROF OFFICE BUILDINGS	78,875	0	0	0	78,875 194.02
194.03 07953	OP PHARMACY	693,607	5,161	3,554	29,124	731,446 194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	250,550	0	0	15,133	265,683 194.04
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers					0 201.00
202.00	TOTAL (sum lines 118 through 201)	116,821,988	6,363,062	4,382,670	5,130,477	116,821,988 202.00

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,639,249				5.00
7.00	00700	OPERATION OF PLANT	1,434,479	7,089,004			7.00
9.00	00900	HOUSEKEEPING	723,517	45,806	3,621,330		9.00
10.00	01000	DIETARY	99,179	241,020	123,923	855,071	10.00
11.00	01100	CAFETERIA	396,107	89,876	46,211	0	2,093,596
13.00	01300	NURSING ADMINISTRATION	451,014	150,097	77,174	0	37,153
14.00	01400	CENTRAL SERVICES & SUPPLY	155,257	159,109	81,808	0	27,833
15.00	01500	PHARMACY	550,116	63,032	32,408	0	67,212
16.00	01600	MEDICAL RECORDS & LIBRARY	150,350	93,735	48,195	0	20,485
17.00	01700	SOCIAL SERVICE	240,934	19,871	10,217	0	25,352
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,749,127	1,571,804	808,158	639,950	535,787
31.00	03100	INTENSIVE CARE UNIT	922,172	325,853	167,541	80,706	123,323
40.00	04000	SUBPROVIDER - IPF	661,640	405,890	208,692	134,415	132,643
43.00	04300	NURSERY	392,593	99,219	51,015	0	65,940
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,902,874	1,004,128	516,282	0	171,545
51.00	05100	RECOVERY ROOM	226,555	98,007	50,391	0	33,972
52.00	05200	DELIVERY ROOM & LABOR ROOM	631,089	349,390	179,642	0	115,562
53.00	05300	ANESTHESIOLOGY	42,363	17,170	8,828	0	3,181
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,002,256	655,316	336,937	0	124,850
56.00	05600	RADIOISOTOPE	121,096	201,305	103,503	0	11,069
57.00	05700	CT SCAN	195,862	36,050	18,535	0	26,433
58.00	05800	MRI	85,493	25,356	13,037	0	13,773
59.00	05900	CARDIAC CATHETERIZATION	188,417	31,006	15,942	0	36,676
60.00	06000	LABORATORY	919,025	109,334	56,215	0	115,593
65.00	06500	RESPIRATORY THERAPY	281,416	14,883	7,652	0	55,538
66.00	06600	PHYSICAL THERAPY	1,173,737	379,404	195,074	0	32
67.00	06700	OCCUPATIONAL THERAPY	21,857	26,293	13,519	0	0
68.00	06800	SPEECH PATHOLOGY	4,797	2,315	1,190	0	0
69.00	06900	ELECTROCARDIOLOGY	172,884	16,178	8,318	0	27,801
70.00	07000	ELECTROENCEPHALOGRAPHY	89,741	38,034	19,556	0	1,845
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,496,310	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,414,929	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,773,108	0	0	0	0
74.00	07400	RENAL DIALYSIS	108,230	0	0	0	0
76.00	03020	ANCILLARY	0	0	0	0	0
76.01	03950	WOUND CARE	13,348	35,829	18,422	0	0
76.97	07697	CARDIAC REHABILITATION	53,876	44,676	22,971	0	5,535
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	406,595	300,524	154,518	0	41,479
91.00	09100	EMERGENCY	1,332,165	403,823	207,630	0	247,632
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,584,508	7,054,333	3,603,504	855,071	2,068,244
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	45,040	22,655	11,648	0	4,676
192.00	19200	PHYSICIANS' PRIVATE OFFICES	685,499	0	0	0	0
194.00	07950	FOUNDATION	51,234	5,567	2,862	0	5,726
194.01	07951	MARKETING	0	0	0	0	0
194.02	07952	PROF OFFICE BUILDINGS	20,010	0	0	0	0
194.03	07953	OP PHARMACY	185,558	6,449	3,316	0	6,934
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	67,400	0	0	0	8,016
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	23,639,249	7,089,004	3,621,330	855,071	2,093,596

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0304

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

Worksheet B
Part I
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	2,493,276					13.00
14.00	01400	0	1,036,008				14.00
15.00	01500	0	164	2,881,414			15.00
16.00	01600	0	0	0	905,423		16.00
17.00	01700	0	0	241	0	1,246,345	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	908,080	594	189	52,097	795,354	30.00
31.00	03100	209,008	4,872	238	9,880	121,304	31.00
40.00	04000	224,829	76	0	11,704	202,035	40.00
43.00	04300	111,777	57	819	6,021	127,652	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	290,742	763,723	4,111	89,609	0	50.00
51.00	05100	57,597	71	8	10,006	0	51.00
52.00	05200	195,867	13,086	274	10,563	0	52.00
53.00	05300	5,366	2,736	51,139	22,516	0	53.00
54.00	05400	0	1,214	226	73,125	0	54.00
56.00	05600	0	0	0	8,528	0	56.00
57.00	05700	0	9	40	89,199	0	57.00
58.00	05800	0	5	40	21,721	0	58.00
59.00	05900	0	59,225	27	8,079	0	59.00
60.00	06000	0	1,173	8	101,745	0	60.00
65.00	06500	0	7	0	17,200	0	65.00
66.00	06600	0	0	0	23,247	0	66.00
67.00	06700	0	0	0	1,797	0	67.00
68.00	06800	0	0	0	975	0	68.00
69.00	06900	0	93	1	25,768	0	69.00
70.00	07000	0	0	0	5,052	0	70.00
71.00	07100	0	55,548	0	21,476	0	71.00
72.00	07200	0	125,533	0	42,550	0	72.00
73.00	07300	0	0	2,822,477	97,516	0	73.00
74.00	07400	0	0	0	2,210	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	2,747	0	9	0	76.01
76.97	07697	0	0	0	1,068	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	70,323	2,360	1,182	12,381	0	90.00
91.00	09100	419,687	2,715	394	139,381	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00
202.00							202.00
		2,493,276	1,036,008	2,881,414	905,423	1,246,345	

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,897,825	0	18,897,825	30.00
31.00	03100	INTENSIVE CARE UNIT	5,599,975	0	5,599,975	31.00
40.00	04000	SUBPROVIDER - IPF	4,590,020	0	4,590,020	40.00
43.00	04300	NURSERY	2,402,640	0	2,402,640	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,243,889	0	12,243,889	50.00
51.00	05100	RECOVERY ROOM	1,369,658	0	1,369,658	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,983,142	0	3,983,142	52.00
53.00	05300	ANESTHESIOLOGY	320,289	0	320,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,144,682	0	6,144,682	54.00
56.00	05600	RADIOISOTOPE	922,847	0	922,847	56.00
57.00	05700	CT SCAN	1,138,190	0	1,138,190	57.00
58.00	05800	MRI	496,426	0	496,426	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,082,087	0	1,082,087	59.00
60.00	06000	LABORATORY	4,925,764	0	4,925,764	60.00
65.00	06500	RESPIRATORY THERAPY	1,485,999	0	1,485,999	65.00
66.00	06600	PHYSICAL THERAPY	6,398,209	0	6,398,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,624	0	149,624	67.00
68.00	06800	SPEECH PATHOLOGY	28,188	0	28,188	68.00
69.00	06900	ELECTROCARDIOLOGY	932,530	0	932,530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	507,975	0	507,975	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,471,585	0	7,471,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,160,473	0	7,160,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,682,454	0	11,682,454	73.00
74.00	07400	RENAL DIALYSIS	537,067	0	537,067	74.00
76.00	03020	ANCILLARY	0	0	0	76.00
76.01	03950	WOUND CARE	122,972	0	122,972	76.01
76.97	07697	CARDIAC REHABILITATION	340,498	0	340,498	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,592,104	0	2,592,104	90.00
91.00	09100	EMERGENCY	8,004,641	0	8,004,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	111,531,753	0	111,531,753	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	261,559	0	261,559	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,387,644	0	3,387,644	192.00
194.00	07950	FOUNDATION	267,345	0	267,345	194.00
194.01	07951	MARKETING	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	98,885	0	98,885	194.02
194.03	07953	OP PHARMACY	933,703	0	933,703	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	341,099	0	341,099	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	116,821,988	0	116,821,988	202.00

Provider CCN: 14-0304

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

Worksheet Non-CMS W

Date/Time Prepared:
 5/29/2018 8:16 am

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
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	2	MEALS SERVED	10.00
11.00	CAFETERIA	3	TOTAL HOURS	11.00
13.00	NURSING ADMINISTRATION	4	TOTAL HOURS	13.00
14.00	CENTRAL SERVICES & SUPPLY	5	COSTED REQUIS.	14.00
15.00	PHARMACY	6	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHAR GES	16.00
17.00	SOCIAL SERVICE	7	PATIENT DA YS	17.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	290,383	200,006	490,389	5.00
7.00 00700	OPERATION OF PLANT	0	400,167	275,622	675,789	7.00
9.00 00900	HOUSEKEEPING	0	36,653	25,246	61,899	9.00
10.00 01000	DIETARY	0	192,861	132,836	325,697	10.00
11.00 01100	CAFETERIA	0	71,918	49,534	121,452	11.00
13.00 01300	NURSING ADMINISTRATION	0	120,105	82,725	202,830	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	127,317	87,692	215,009	14.00
15.00 01500	PHARMACY	0	50,437	34,739	85,176	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	75,005	51,661	126,666	16.00
17.00 01700	SOCIAL SERVICE	0	15,901	10,952	26,853	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,257,728	866,284	2,124,012	30.00
31.00 03100	INTENSIVE CARE UNIT	0	260,743	179,591	440,334	31.00
40.00 04000	SUBPROVIDER - IPF	0	324,787	223,703	548,490	40.00
43.00 04300	NURSERY	0	79,394	54,684	134,078	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	803,488	553,416	1,356,904	50.00
51.00 05100	RECOVERY ROOM	0	78,423	54,016	132,439	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	279,577	192,563	472,140	52.00
53.00 05300	ANESTHESIOLOGY	0	13,740	9,463	23,203	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	524,374	361,172	885,546	54.00
56.00 05600	RADIOISOTOPE	0	161,081	110,948	272,029	56.00
57.00 05700	CT SCAN	0	28,846	19,868	48,714	57.00
58.00 05800	MRI	0	20,290	13,975	34,265	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	24,811	17,089	41,900	59.00
60.00 06000	LABORATORY	0	87,488	60,259	147,747	60.00
65.00 06500	RESPIRATORY THERAPY	0	11,909	8,203	20,112	65.00
66.00 06600	PHYSICAL THERAPY	0	303,593	209,105	512,698	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	21,039	14,491	35,530	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,853	1,276	3,129	68.00
69.00 06900	ELECTROCARDIOLOGY	0	12,946	8,917	21,863	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	30,434	20,962	51,396	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03020	ANCILLARY	0	0	0	0	76.00
76.01 03950	WOUND CARE	0	28,670	19,747	48,417	76.01
76.97 07697	CARDIAC REHABILITATION	0	35,749	24,623	60,372	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	240,475	165,631	406,106	90.00
91.00 09100	EMERGENCY	0	323,133	222,563	545,696	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6,335,318	4,363,562	10,698,880	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,128	12,486	30,614	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	FOUNDATION	0	4,455	3,068	7,523	194.00
194.01 07951	MARKETING	0	0	0	0	194.01
194.02 07952	PROF OFFICE BUILDINGS	0	0	0	0	194.02
194.03 07953	OP PHARMACY	0	5,161	3,554	8,715	194.03
194.04 07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.04
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	6,363,062	4,382,670	10,745,732	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

Worksheet B
Part II
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	490,389				5.00
7.00	00700	OPERATION OF PLANT	29,760	705,549			7.00
9.00	00900	HOUSEKEEPING	15,010	4,559	81,468		9.00
10.00	01000	DIETARY	2,058	23,988	2,788	354,531	10.00
11.00	01100	CAFETERIA	8,218	8,945	1,040	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,357	14,939	1,736	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,221	15,836	1,840	0	14.00
15.00	01500	PHARMACY	11,413	6,273	729	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,119	9,329	1,084	0	16.00
17.00	01700	SOCIAL SERVICE	4,998	1,978	230	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	57,003	156,438	18,180	265,338	30.00
31.00	03100	INTENSIVE CARE UNIT	19,131	32,431	3,769	33,462	31.00
40.00	04000	SUBPROVIDER - IPF	13,726	40,397	4,695	55,731	40.00
43.00	04300	NURSERY	8,145	9,875	1,148	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	39,477	99,938	11,615	0	50.00
51.00	05100	RECOVERY ROOM	4,700	9,754	1,134	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,093	34,774	4,041	0	52.00
53.00	05300	ANESTHESIOLOGY	879	1,709	199	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,793	65,222	7,580	0	54.00
56.00	05600	RADIOISOTOPE	2,512	20,035	2,328	0	56.00
57.00	05700	CT SCAN	4,063	3,588	417	0	57.00
58.00	05800	MRI	1,774	2,524	293	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,909	3,086	359	0	59.00
60.00	06000	LABORATORY	19,066	10,882	1,265	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,838	1,481	172	0	65.00
66.00	06600	PHYSICAL THERAPY	24,350	37,761	4,389	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	453	2,617	304	0	67.00
68.00	06800	SPEECH PATHOLOGY	100	230	27	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,587	1,610	187	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,862	3,785	440	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	31,042	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,354	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,785	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,245	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	76.00
76.01	03950	WOUND CARE	277	3,566	414	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,118	4,447	517	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	8,435	29,910	3,476	0	90.00
91.00	09100	EMERGENCY	27,637	40,191	4,671	0	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)	468,508	702,098	81,067	354,531	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	934	2,255	262	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,221	0	0	0	192.00
194.00	07950	FOUNDATION	1,063	554	64	0	194.00
194.01	07951	MARKETING	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	415	0	0	0	194.02
194.03	07953	OP PHARMACY	3,850	642	75	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	1,398	0	0	0	194.04
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	490,389	705,549	81,468	354,531	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	231,340					13.00
14.00	01400	0	237,763				14.00
15.00	01500	0	38	108,112			15.00
16.00	01600	0	0	0	141,564		16.00
17.00	01700	0	0	9	0	35,759	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	84,256	136	7	8,143	22,820	30.00
31.00	03100	19,393	1,118	9	1,544	3,480	31.00
40.00	04000	20,861	17	0	1,829	5,797	40.00
43.00	04300	10,371	13	31	941	3,662	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	26,977	175,275	154	14,006	0	50.00
51.00	05100	5,344	16	0	1,564	0	51.00
52.00	05200	18,174	3,003	10	1,651	0	52.00
53.00	05300	498	628	1,919	3,519	0	53.00
54.00	05400	0	279	8	11,430	0	54.00
56.00	05600	0	0	0	1,333	0	56.00
57.00	05700	0	2	2	13,942	0	57.00
58.00	05800	0	1	2	3,395	0	58.00
59.00	05900	0	13,592	1	1,263	0	59.00
60.00	06000	0	269	0	15,903	0	60.00
65.00	06500	0	2	0	2,688	0	65.00
66.00	06600	0	0	0	3,634	0	66.00
67.00	06700	0	0	0	281	0	67.00
68.00	06800	0	0	0	152	0	68.00
69.00	06900	0	21	0	4,028	0	69.00
70.00	07000	0	0	0	790	0	70.00
71.00	07100	0	12,748	0	3,357	0	71.00
72.00	07200	0	28,810	0	6,651	0	72.00
73.00	07300	0	0	105,901	15,242	0	73.00
74.00	07400	0	0	0	345	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.01	03950	0	630	0	1	0	76.01
76.97	07697	0	0	0	167	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	6,525	542	44	1,935	0	90.00
91.00	09100	38,941	623	15	21,830	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		231,340	237,763	108,112	141,564	35,759	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		231,340	237,763	108,112	141,564	35,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0304

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,772,075	0	2,772,075
31.00	03100	INTENSIVE CARE UNIT	562,897	0	562,897
40.00	04000	SUBPROVIDER - IPF	700,391	0	700,391
43.00	04300	NURSERY	172,663	0	172,663
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,735,789	0	1,735,789
51.00	05100	RECOVERY ROOM	157,217	0	157,217
52.00	05200	DELIVERY ROOM & LABOR ROOM	554,595	0	554,595
53.00	05300	ANESTHESIOLOGY	32,766	0	32,766
54.00	05400	RADIOLOGY-DIAGNOSTIC	999,186	0	999,186
56.00	05600	RADIOISOTOPE	298,975	0	298,975
57.00	05700	CT SCAN	72,491	0	72,491
58.00	05800	MRI	43,173	0	43,173
59.00	05900	CARDIAC CATHETERIZATION	66,556	0	66,556
60.00	06000	LABORATORY	202,843	0	202,843
65.00	06500	RESPIRATORY THERAPY	33,998	0	33,998
66.00	06600	PHYSICAL THERAPY	582,834	0	582,834
67.00	06700	OCCUPATIONAL THERAPY	39,185	0	39,185
68.00	06800	SPEECH PATHOLOGY	3,638	0	3,638
69.00	06900	ELECTROCARDIOLOGY	33,150	0	33,150
70.00	07000	ELECTROENCEPHALOGRAPHY	58,396	0	58,396
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,147	0	47,147
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,815	0	64,815
73.00	07300	DRUGS CHARGED TO PATIENTS	157,928	0	157,928
74.00	07400	RENAL DIALYSIS	2,590	0	2,590
76.00	03020	ANCILLARY	0	0	0
76.01	03950	WOUND CARE	53,305	0	53,305
76.97	07697	CARDIAC REHABILITATION	66,990	0	66,990
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	459,740	0	459,740
91.00	09100	EMERGENCY	696,122	0	696,122
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)	10,671,455	0	10,671,455
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,377	0	34,377
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,221	0	14,221
194.00	07950	FOUNDATION	9,586	0	9,586
194.01	07951	MARKETING	0	0	0
194.02	07952	PROF OFFICE BUILDINGS	415	0	415
194.03	07953	OP PHARMACY	13,745	0	13,745
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	1,933	0	1,933
200.00		Cross Foot Adjustments	0	0	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	10,745,732	0	10,745,732

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	288,524			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		288,524		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	38,621,781	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,167	13,167	3,725,474	5.00
7.00	00700	OPERATION OF PLANT	18,145	18,145	1,395,356	7.00
9.00	00900	HOUSEKEEPING	1,662	1,662	0	9.00
10.00	01000	DIETARY	8,745	8,745	778	10.00
11.00	01100	CAFETERIA	3,261	3,261	0	11.00
13.00	01300	NURSING ADMINISTRATION	5,446	5,446	930,282	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,773	5,773	248,346	14.00
15.00	01500	PHARMACY	2,287	2,287	1,612,797	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,401	3,401	297,806	16.00
17.00	01700	SOCIAL SERVICE	721	721	703,355	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	57,030	57,030	6,827,333	30.00
31.00	03100	INTENSIVE CARE UNIT	11,823	11,823	2,171,166	31.00
40.00	04000	SUBPROVIDER - IPF	14,727	14,727	1,654,215	40.00
43.00	04300	NURSERY	3,600	3,600	1,007,652	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,433	36,433	3,485,955	50.00
51.00	05100	RECOVERY ROOM	3,556	3,556	622,154	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,677	12,677	1,835,085	52.00
53.00	05300	ANESTHESIOLOGY	623	623	51,492	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,777	23,777	2,225,131	54.00
56.00	05600	RADIOISOTOPE	7,304	7,304	165,676	56.00
57.00	05700	CT SCAN	1,308	1,308	479,820	57.00
58.00	05800	MRI	920	920	229,445	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,125	1,125	514,585	59.00
60.00	06000	LABORATORY	3,967	3,967	1,768,808	60.00
65.00	06500	RESPIRATORY THERAPY	540	540	794,603	65.00
66.00	06600	PHYSICAL THERAPY	13,766	13,766	398	66.00
67.00	06700	OCCUPATIONAL THERAPY	954	954	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	68.00
69.00	06900	ELECTROCARDIOLOGY	587	587	523,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,380	1,380	29,519	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	76.00
76.01	03950	WOUND CARE	1,300	1,300	306	76.01
76.97	07697	CARDIAC REHABILITATION	1,621	1,621	127,424	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,904	10,904	936,130	90.00
91.00	09100	EMERGENCY	14,652	14,652	3,682,139	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)	287,266	287,266	38,047,115	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	822	822	92,988	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
194.00	07950	FOUNDATION	202	202	148,518	194.00
194.01	07951	MARKETING	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	194.02
194.03	07953	OP PHARMACY	234	234	219,240	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	113,920	194.04
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per wkst. B, Part I)	6,363,062	4,382,670	5,130,477	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	22.053840	15.189967	0.132839	203.00
204.00		Cost to be allocated (per wkst. B, Part II)			0	204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per wkst. B-2)				206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0304

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	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	5A	5.00	207.00

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (TOTAL HOURS)	NURSING ADMINISTRATION (TOTAL HOURS)		
		7.00	9.00	10.00	11.00	13.00		
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	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	257,212				7.00	
9.00	00900	HOUSEKEEPING	1,662	255,550			9.00	
10.00	01000	DIETARY	8,745	8,745	104,741		10.00	
11.00	01100	CAFETERIA	3,261	3,261	0	65,818	11.00	
13.00	01300	NURSING ADMINISTRATION	5,446	5,446	0	1,168	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	5,773	5,773	0	875	14.00	
15.00	01500	PHARMACY	2,287	2,287	0	2,113	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	3,401	3,401	0	644	16.00	
17.00	01700	SOCIAL SERVICE	721	721	0	797	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	57,030	57,030	78,390	16,844	363,836	30.00
31.00	03100	INTENSIVE CARE UNIT	11,823	11,823	9,886	3,877	83,742	31.00
40.00	04000	SUBPROVIDER - IPF	14,727	14,727	16,465	4,170	90,081	40.00
43.00	04300	NURSERY	3,600	3,600	0	2,073	44,785	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,433	36,433	0	5,393	116,490	50.00
51.00	05100	RECOVERY ROOM	3,556	3,556	0	1,068	23,077	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,677	12,677	0	3,633	78,477	52.00
53.00	05300	ANESTHESIOLOGY	623	623	0	100	2,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,777	23,777	0	3,925	0	54.00
56.00	05600	RADIOISOTOPE	7,304	7,304	0	348	0	56.00
57.00	05700	CT SCAN	1,308	1,308	0	831	0	57.00
58.00	05800	MRI	920	920	0	433	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,125	1,125	0	1,153	0	59.00
60.00	06000	LABORATORY	3,967	3,967	0	3,634	0	60.00
65.00	06500	RESPIRATORY THERAPY	540	540	0	1,746	0	65.00
66.00	06600	PHYSICAL THERAPY	13,766	13,766	0	1	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	954	954	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	84	84	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	587	587	0	874	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,380	1,380	0	58	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	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	1,300	1,300	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	1,621	1,621	0	174	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	10,904	10,904	0	1,304	28,176	90.00
91.00	09100	EMERGENCY	14,652	14,652	0	7,785	168,154	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)	255,954	254,292	104,741	65,021	998,968	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	822	822	0	147	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FOUNDATION	202	202	0	180	0	194.00
194.01	07951	MARKETING	0	0	0	0	0	194.01
194.02	07952	PROF OFFICE BUILDINGS	0	0	0	0	0	194.02
194.03	07953	OP PHARMACY	234	234	0	218	0	194.03
194.04	07954	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	252	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per wkst. B, Part I)	7,089,004	3,621,330	855,071	2,093,596	2,493,276	202.00
203.00		Unit cost multiplier (wkst. B, Part I)	27.560938	14.170730	8.163670	31.808867	2.495852	203.00
204.00		Cost to be allocated (per wkst. B, Part II)	705,549	81,468	354,531	139,655	231,340	204.00
205.00		Unit cost multiplier (wkst. B, Part II)	2.743064	0.318795	3.384835	2.121836	0.231579	205.00
206.00		NAHE adjustment amount to be allocated (per wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0304

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

Worksheet B-1

Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
7.00	00700					7.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
14.00	01400	6,970,948				14.00
15.00	01500	1,103	7,159,834			15.00
16.00	01600	0	0	516,617,362		16.00
17.00	01700	0	600	0	27,094	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	3,999	469	29,718,845	17,290	30.00
31.00	03100	32,785	591	5,636,100	2,637	31.00
40.00	04000	512	0	6,676,455	4,392	40.00
43.00	04300	384	2,036	3,434,840	2,775	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	5,138,825	10,215	51,117,340	0	50.00
51.00	05100	479	19	5,707,939	0	51.00
52.00	05200	88,054	680	6,025,908	0	52.00
53.00	05300	18,407	127,072	12,844,005	0	53.00
54.00	05400	8,169	562	41,714,272	0	54.00
56.00	05600	0	0	4,864,800	0	56.00
57.00	05700	62	100	50,883,653	0	57.00
58.00	05800	37	100	12,390,700	0	58.00
59.00	05900	398,507	68	4,608,550	0	59.00
60.00	06000	7,893	19	58,040,256	0	60.00
65.00	06500	44	0	9,811,848	0	65.00
66.00	06600	0	0	13,261,499	0	66.00
67.00	06700	0	0	1,025,081	0	67.00
68.00	06800	0	0	555,938	0	68.00
69.00	06900	625	3	14,699,227	0	69.00
70.00	07000	0	0	2,881,905	0	70.00
71.00	07100	373,765	0	12,251,229	0	71.00
72.00	07200	844,666	0	24,272,634	0	72.00
73.00	07300	0	7,013,386	55,628,258	0	73.00
74.00	07400	0	0	1,260,800	0	74.00
76.00	03020	0	0	0	0	76.00
76.01	03950	18,483	0	5,127	0	76.01
76.97	07697	0	0	609,405	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	15,882	2,936	7,062,513	0	90.00
91.00	09100	18,267	978	79,628,235	0	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		6,970,948	7,159,834	516,617,362	27,094	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	0	0	0	190.00
192.00	19200	0	0	0	0	192.00
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
194.02	07952	0	0	0	0	194.02
194.03	07953	0	0	0	0	194.03
194.04	07954	0	0	0	0	194.04
200.00						200.00
201.00						201.00
202.00		1,036,008	2,881,414	905,423	1,246,345	202.00
203.00		0.148618	0.402441	0.001753	46.000775	203.00
204.00		237,763	108,112	141,564	35,759	204.00
205.00		0.034108	0.015100	0.000274	1.319813	205.00
206.00						206.00
207.00						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		Total Cost (from wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		PPS
				Total Costs	RCE Disallowance	Total Costs		
								3.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,897,825		18,897,825	0	18,897,825	30.00
31.00	03100	INTENSIVE CARE UNIT	5,599,975		5,599,975	0	5,599,975	31.00
40.00	04000	SUBPROVIDER - IPF	4,590,020		4,590,020	0	4,590,020	40.00
43.00	04300	NURSERY	2,402,640		2,402,640	0	2,402,640	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,243,889		12,243,889	0	12,243,889	50.00
51.00	05100	RECOVERY ROOM	1,369,658		1,369,658	0	1,369,658	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,983,142		3,983,142	0	3,983,142	52.00
53.00	05300	ANESTHESIOLOGY	320,289		320,289	0	320,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,144,682		6,144,682	0	6,144,682	54.00
56.00	05600	RADIOISOTOPE	922,847		922,847	0	922,847	56.00
57.00	05700	CT SCAN	1,138,190		1,138,190	0	1,138,190	57.00
58.00	05800	MRI	496,426		496,426	0	496,426	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,082,087		1,082,087	0	1,082,087	59.00
60.00	06000	LABORATORY	4,925,764		4,925,764	0	4,925,764	60.00
65.00	06500	RESPIRATORY THERAPY	1,485,999	0	1,485,999	0	1,485,999	65.00
66.00	06600	PHYSICAL THERAPY	6,398,209	0	6,398,209	0	6,398,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,624	0	149,624	0	149,624	67.00
68.00	06800	SPEECH PATHOLOGY	28,188	0	28,188	0	28,188	68.00
69.00	06900	ELECTROCARDIOLOGY	932,530		932,530	0	932,530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	507,975		507,975	0	507,975	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,471,585		7,471,585	0	7,471,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,160,473		7,160,473	0	7,160,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,682,454		11,682,454	0	11,682,454	73.00
74.00	07400	RENAL DIALYSIS	537,067		537,067	0	537,067	74.00
76.00	03020	ANCILLARY	0		0	0	0	76.00
76.01	03950	WOUND CARE	122,972		122,972	0	122,972	76.01
76.97	07697	CARDIAC REHABILITATION	340,498		340,498	0	340,498	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,592,104		2,592,104	0	2,592,104	90.00
91.00	09100	EMERGENCY	8,004,641		8,004,641	0	8,004,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,271,647		3,271,647	0	3,271,647	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	114,803,400	0	114,803,400	0	114,803,400	200.00
201.00		Less Observation Beds	3,271,647		3,271,647		3,271,647	201.00
202.00		Total (see instructions)	111,531,753	0	111,531,753	0	111,531,753	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		Title XVIII			Hospital	PPS
		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	21,789,077		21,789,077	30.00
31.00	03100	INTENSIVE CARE UNIT	5,636,100		5,636,100	31.00
40.00	04000	SUBPROVIDER - IPF	6,676,455		6,676,455	40.00
43.00	04300	NURSERY	3,434,840		3,434,840	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,143,680	39,973,660	51,117,340	0.239525 50.00
51.00	05100	RECOVERY ROOM	1,719,546	3,988,393	5,707,939	0.239957 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,150,628	875,280	6,025,908	0.661003 52.00
53.00	05300	ANESTHESIOLOGY	4,295,045	8,548,960	12,844,005	0.024937 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,759,437	33,954,835	41,714,272	0.147304 54.00
56.00	05600	RADIOISOTOPE	1,063,300	3,801,500	4,864,800	0.189699 56.00
57.00	05700	CT SCAN	13,207,010	37,676,643	50,883,653	0.022368 57.00
58.00	05800	MRI	2,703,300	9,687,400	12,390,700	0.040064 58.00
59.00	05900	CARDIAC CATHETERIZATION	3,368,500	1,240,050	4,608,550	0.234800 59.00
60.00	06000	LABORATORY	26,644,929	31,395,327	58,040,256	0.084868 60.00
65.00	06500	RESPIRATORY THERAPY	8,532,551	1,279,297	9,811,848	0.151449 65.00
66.00	06600	PHYSICAL THERAPY	1,725,332	11,536,167	13,261,499	0.482465 66.00
67.00	06700	OCCUPATIONAL THERAPY	913,753	111,328	1,025,081	0.145963 67.00
68.00	06800	SPEECH PATHOLOGY	495,496	60,442	555,938	0.050703 68.00
69.00	06900	ELECTROCARDIOLOGY	5,543,754	9,155,473	14,699,227	0.063441 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,810	2,724,095	2,881,905	0.176264 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,379,458	7,871,771	12,251,229	0.609864 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,635,158	17,637,476	24,272,634	0.295002 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,084,355	33,543,903	55,628,258	0.210009 73.00
74.00	07400	RENAL DIALYSIS	1,260,800	0	1,260,800	0.425973 74.00
76.00	03020	ANCILLARY	0	0	0	0.000000 76.00
76.01	03950	WOUND CARE	0	5,127	5,127	23.985177 76.01
76.97	07697	CARDIAC REHABILITATION	9,340	600,065	609,405	0.558738 76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	62,195	7,000,318	7,062,513	0.367023 90.00
91.00	09100	EMERGENCY	15,519,934	64,108,301	79,628,235	0.100525 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,562,850	6,366,918	7,929,768	0.412578 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	183,474,633	333,142,729	516,617,362	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	183,474,633	333,142,729	516,617,362	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		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	0.239525			50.00
51.00	05100 RECOVERY ROOM	0.239957			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.661003			52.00
53.00	05300 ANESTHESIOLOGY	0.024937			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147304			54.00
56.00	05600 RADIOISOTOPE	0.189699			56.00
57.00	05700 CT SCAN	0.022368			57.00
58.00	05800 MRI	0.040064			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.234800			59.00
60.00	06000 LABORATORY	0.084868			60.00
65.00	06500 RESPIRATORY THERAPY	0.151449			65.00
66.00	06600 PHYSICAL THERAPY	0.482465			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.145963			67.00
68.00	06800 SPEECH PATHOLOGY	0.050703			68.00
69.00	06900 ELECTROCARDIOLOGY	0.063441			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.176264			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.609864			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.295002			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.210009			73.00
74.00	07400 RENAL DIALYSIS	0.425973			74.00
76.00	03020 ANCILLARY	0.000000			76.00
76.01	03950 WOUND CARE	23.985177			76.01
76.97	07697 CARDIAC REHABILITATION	0.558738			76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.367023			90.00
91.00	09100 EMERGENCY	0.100525			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.412578			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: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XIX		Hospital		Cost
				Total Costs	RCE Disallowance	Total Costs	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,897,825		18,897,825	0	18,897,825	30.00
31.00	03100	INTENSIVE CARE UNIT	5,599,975		5,599,975	0	5,599,975	31.00
40.00	04000	SUBPROVIDER - IPF	4,590,020		4,590,020	0	4,590,020	40.00
43.00	04300	NURSERY	2,402,640		2,402,640	0	2,402,640	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,243,889		12,243,889	0	12,243,889	50.00
51.00	05100	RECOVERY ROOM	1,369,658		1,369,658	0	1,369,658	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,983,142		3,983,142	0	3,983,142	52.00
53.00	05300	ANESTHESIOLOGY	320,289		320,289	0	320,289	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,144,682		6,144,682	0	6,144,682	54.00
56.00	05600	RADIOISOTOPE	922,847		922,847	0	922,847	56.00
57.00	05700	CT SCAN	1,138,190		1,138,190	0	1,138,190	57.00
58.00	05800	MRI	496,426		496,426	0	496,426	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,082,087		1,082,087	0	1,082,087	59.00
60.00	06000	LABORATORY	4,925,764		4,925,764	0	4,925,764	60.00
65.00	06500	RESPIRATORY THERAPY	1,485,999	0	1,485,999	0	1,485,999	65.00
66.00	06600	PHYSICAL THERAPY	6,398,209	0	6,398,209	0	6,398,209	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,624	0	149,624	0	149,624	67.00
68.00	06800	SPEECH PATHOLOGY	28,188	0	28,188	0	28,188	68.00
69.00	06900	ELECTROCARDIOLOGY	932,530		932,530	0	932,530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	507,975		507,975	0	507,975	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,471,585		7,471,585	0	7,471,585	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,160,473		7,160,473	0	7,160,473	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,682,454		11,682,454	0	11,682,454	73.00
74.00	07400	RENAL DIALYSIS	537,067		537,067	0	537,067	74.00
76.00	03020	ANCILLARY	0		0	0	0	76.00
76.01	03950	WOUND CARE	122,972		122,972	0	122,972	76.01
76.97	07697	CARDIAC REHABILITATION	340,498		340,498	0	340,498	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	2,592,104		2,592,104	0	2,592,104	90.00
91.00	09100	EMERGENCY	8,004,641		8,004,641	0	8,004,641	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,271,647		3,271,647	0	3,271,647	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	114,803,400	0	114,803,400	0	114,803,400	200.00
201.00		Less Observation Beds	3,271,647		3,271,647		3,271,647	201.00
202.00		Total (see instructions)	111,531,753	0	111,531,753	0	111,531,753	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 8:16 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	21,789,077		21,789,077				30.00
31.00	03100	INTENSIVE CARE UNIT	5,636,100		5,636,100				31.00
40.00	04000	SUBPROVIDER - IPF	6,676,455		6,676,455				40.00
43.00	04300	NURSERY	3,434,840		3,434,840				43.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	11,143,680	39,973,660	51,117,340	0.239525	0.239525		50.00
51.00	05100	RECOVERY ROOM	1,719,546	3,988,393	5,707,939	0.239957	0.239957		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,150,628	875,280	6,025,908	0.661003	0.661003		52.00
53.00	05300	ANESTHESIOLOGY	4,295,045	8,548,960	12,844,005	0.024937	0.024937		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,759,437	33,954,835	41,714,272	0.147304	0.147304		54.00
56.00	05600	RADIOISOTOPE	1,063,300	3,801,500	4,864,800	0.189699	0.189699		56.00
57.00	05700	CT SCAN	13,207,010	37,676,643	50,883,653	0.022368	0.022368		57.00
58.00	05800	MRI	2,703,300	9,687,400	12,390,700	0.040064	0.040064		58.00
59.00	05900	CARDIAC CATHETERIZATION	3,368,500	1,240,050	4,608,550	0.234800	0.234800		59.00
60.00	06000	LABORATORY	26,644,929	31,395,327	58,040,256	0.084868	0.084868		60.00
65.00	06500	RESPIRATORY THERAPY	8,532,551	1,279,297	9,811,848	0.151449	0.151449		65.00
66.00	06600	PHYSICAL THERAPY	1,725,332	11,536,167	13,261,499	0.482465	0.482465		66.00
67.00	06700	OCCUPATIONAL THERAPY	913,753	111,328	1,025,081	0.145963	0.145963		67.00
68.00	06800	SPEECH PATHOLOGY	495,496	60,442	555,938	0.050703	0.050703		68.00
69.00	06900	ELECTROCARDIOLOGY	5,543,754	9,155,473	14,699,227	0.063441	0.063441		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157,810	2,724,095	2,881,905	0.176264	0.176264		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,379,458	7,871,771	12,251,229	0.609864	0.609864		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,635,158	17,637,476	24,272,634	0.295002	0.295002		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,084,355	33,543,903	55,628,258	0.210009	0.210009		73.00
74.00	07400	RENAL DIALYSIS	1,260,800	0	1,260,800	0.425973	0.425973		74.00
76.00	03020	ANCILLARY	0	0	0	0.000000	0.000000		76.00
76.01	03950	WOUND CARE	0	5,127	5,127	23.985177	23.985177		76.01
76.97	07697	CARDIAC REHABILITATION	9,340	600,065	609,405	0.558738	0.558738		76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	62,195	7,000,318	7,062,513	0.367023	0.367023		90.00
91.00	09100	EMERGENCY	15,519,934	64,108,301	79,628,235	0.100525	0.100525		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,562,850	6,366,918	7,929,768	0.412578	0.412578		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	183,474,633	333,142,729	516,617,362				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	183,474,633	333,142,729	516,617,362				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0304

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

Worksheet C
Part I
Date/Time Prepared:
5/29/2018 8:16 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	03020	ANCILLARY	0.000000		76.00
76.01	03950	WOUND CARE	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
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: 14-0304

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

Worksheet D
Part I
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Capital Related Cost (from wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,772,075	0	2,772,075	20,910	132.57	30.00	
31.00	INTENSIVE CARE UNIT	562,897		562,897	2,637	213.46	31.00	
40.00	SUBPROVIDER - IPF	700,391	0	700,391	4,392	159.47	40.00	
43.00	NURSERY	172,663		172,663	2,775	62.22	43.00	
200.00	Total (lines 30 through 199)	4,208,026		4,208,026	30,714		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	6,369	844,338					30.00
31.00	INTENSIVE CARE UNIT	873	186,351					31.00
40.00	SUBPROVIDER - IPF	3,588	572,178					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	10,830	1,602,867					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0304

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

Worksheet D
Part II
Date/Time Prepared:
5/29/2018 8:16 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	1,735,789	51,117,340	0.033957	3,759,004	127,644	50.00
51.00	05100	RECOVERY ROOM	157,217	5,707,939	0.027544	479,127	13,197	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	554,595	6,025,908	0.092035	5,068	466	52.00
53.00	05300	ANESTHESIOLOGY	32,766	12,844,005	0.002551	1,123,123	2,865	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	999,186	41,714,272	0.023953	2,951,852	70,706	54.00
56.00	05600	RADIOISOTOPE	298,975	4,864,800	0.061457	453,619	27,878	56.00
57.00	05700	CT SCAN	72,491	50,883,653	0.001425	4,582,126	6,530	57.00
58.00	05800	MRI	43,173	12,390,700	0.003484	1,060,466	3,695	58.00
59.00	05900	CARDIAC CATHETERIZATION	66,556	4,608,550	0.014442	1,072,539	15,490	59.00
60.00	06000	LABORATORY	202,843	58,040,256	0.003495	10,038,429	35,084	60.00
65.00	06500	RESPIRATORY THERAPY	33,998	9,811,848	0.003465	3,889,714	13,478	65.00
66.00	06600	PHYSICAL THERAPY	582,834	13,261,499	0.043949	783,917	34,452	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,185	1,025,081	0.038226	413,866	15,820	67.00
68.00	06800	SPEECH PATHOLOGY	3,638	555,938	0.006544	338,447	2,215	68.00
69.00	06900	ELECTROCARDIOLOGY	33,150	14,699,227	0.002255	2,344,159	5,286	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	58,396	2,881,905	0.020263	67,621	1,370	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,147	12,251,229	0.003848	1,486,666	5,721	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,815	24,272,634	0.002670	2,558,518	6,831	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,928	55,628,258	0.002839	7,516,746	21,340	73.00
74.00	07400	RENAL DIALYSIS	2,590	1,260,800	0.002054	656,382	1,348	74.00
76.00	03020	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03950	WOUND CARE	53,305	5,127	10.396918	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	66,990	609,405	0.109927	2,946	324	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	459,740	7,062,513	0.065096	13,484	878	90.00
91.00	09100	EMERGENCY	696,122	79,628,235	0.008742	5,790,537	50,621	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	479,911	7,929,768	0.060520	599,715	36,295	92.00
200.00		Total (lines 50 through 199)	6,943,340	479,080,890		51,988,071	499,534	200.00

Cost Center Description		Title XVIII			Hospital		PPS	
		Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All other Medical Education Cost		
		1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	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	20,910	0.00	6,369	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,637	0.00	873	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,392	0.00	3,588	40.00
43.00	04300	NURSERY	0	0	2,775	0.00	0	43.00
200.00		Total (lines 30 through 199)	0	0	30,714		10,830	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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description	Title XVIII				Hospital		Allied Health	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	03020	ANCILLARY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
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: 14-0304

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 8:16 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	51,117,340	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,707,939	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,025,908	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,844,005	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,714,272	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,864,800	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	50,883,653	0.000000	57.00
58.00	05800	MRI	0	0	0	12,390,700	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,608,550	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,040,256	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,811,848	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,261,499	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,025,081	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	555,938	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,699,227	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,881,905	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,251,229	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,272,634	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	55,628,258	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,260,800	0.000000	74.00
76.00	03020	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03950	WOUND CARE	0	0	0	5,127	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	609,405	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,062,513	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	79,628,235	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,929,768	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	479,080,890		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		Title XVIII				Hospital	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	PPS	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	3,759,004		0	8,874,108	0 50.00
51.00	05100 RECOVERY ROOM	0.000000	479,127		0	541,051	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	5,068		0	3,394	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	1,123,123		0	1,402,458	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,951,852		0	5,003,749	0 54.00
56.00	05600 RADIOISOTOPE	0.000000	453,619		0	1,254,247	0 56.00
57.00	05700 CT SCAN	0.000000	4,582,126		0	6,437,878	0 57.00
58.00	05800 MRI	0.000000	1,060,466		0	1,849,017	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,072,539		0	446,949	0 59.00
60.00	06000 LABORATORY	0.000000	10,038,429		0	688,695	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	3,889,714		0	277,790	0 65.00
66.00	06600 PHYSICAL THERAPY	0.000000	783,917		0	67,620	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	413,866		0	29,180	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	338,447		0	7,200	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	2,344,159		0	1,872,717	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	67,621		0	521,219	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,486,666		0	1,788,907	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,558,518		0	3,673,947	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	7,516,746		0	12,428,828	0 73.00
74.00	07400 RENAL DIALYSIS	0.000000	656,382		0	0	0 74.00
76.00	03020 ANCILLARY	0.000000	0		0	0	0 76.00
76.01	03950 WOUND CARE	0.000000	0		0	5,127	0 76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	2,946		0	273,056	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	13,484		0	1,165,108	0 90.00
91.00	09100 EMERGENCY	0.000000	5,790,537		0	5,885,925	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	599,715		0	1,316,775	0 92.00
200.00	Total (lines 50 through 199)		51,988,071		0	55,814,945	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 8:16 am

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	03020 ANCILLARY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
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: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 8:16 am
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Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Hospital		PPS	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.239525	8,874,108	0	0	2,125,571	50.00
51.00	05100 RECOVERY ROOM	0.239957	541,051	0	0	129,829	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.661003	3,394	0	0	2,243	52.00
53.00	05300 ANESTHESIOLOGY	0.024937	1,402,458	0	0	34,973	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147304	5,003,749	0	0	737,072	54.00
56.00	05600 RADIOISOTOPE	0.189699	1,254,247	0	0	237,929	56.00
57.00	05700 CT SCAN	0.022368	6,437,878	0	0	144,002	57.00
58.00	05800 MRI	0.040064	1,849,017	0	0	74,079	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.234800	446,949	0	0	104,944	59.00
60.00	06000 LABORATORY	0.084868	688,695	0	0	58,448	60.00
65.00	06500 RESPIRATORY THERAPY	0.151449	277,790	0	0	42,071	65.00
66.00	06600 PHYSICAL THERAPY	0.482465	67,620	0	0	32,624	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.145963	29,180	0	0	4,259	67.00
68.00	06800 SPEECH PATHOLOGY	0.050703	7,200	0	0	365	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063441	1,872,717	0	0	118,807	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.176264	521,219	0	0	91,872	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.609864	1,788,907	0	0	1,090,990	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.295002	3,673,947	0	0	1,083,822	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.210009	12,428,828	0	60,750	2,610,166	73.00
74.00	07400 RENAL DIALYSIS	0.425973	0	0	0	0	74.00
76.00	03020 ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950 WOUND CARE	23.985177	5,127	0	0	122,972	76.01
76.97	07697 CARDIAC REHABILITATION	0.558738	273,056	0	0	152,567	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.367023	1,165,108	0	0	427,621	90.00
91.00	09100 EMERGENCY	0.100525	5,885,925	0	0	591,683	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.412578	1,316,775	0	0	543,272	92.00
200.00	Subtotal (see instructions)		55,814,945	0	60,750	10,562,181	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		55,814,945	0	60,750	10,562,181	202.00

		Title XVIII		Hospital	PPS
Cost Center Description		Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 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	12,758	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03020	ANCILLARY	0	0	76.00
76.01	03950	WOUND CARE	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
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	12,758	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	12,758	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0304 Component CCN: 14-S304		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 5/29/2018 8:16 am	
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	1,735,789	51,117,340	0.033957	0	0	50.00
51.00	05100	RECOVERY ROOM	157,217	5,707,939	0.027544	49,500	1,363	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	554,595	6,025,908	0.092035	0	0	52.00
53.00	05300	ANESTHESIOLOGY	32,766	12,844,005	0.002551	90,000	230	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	999,186	41,714,272	0.023953	60,810	1,457	54.00
56.00	05600	RADIOISOTOPE	298,975	4,864,800	0.061457	0	0	56.00
57.00	05700	CT SCAN	72,491	50,883,653	0.001425	131,375	187	57.00
58.00	05800	MRI	43,173	12,390,700	0.003484	2,700	9	58.00
59.00	05900	CARDIAC CATHETERIZATION	66,556	4,608,550	0.014442	0	0	59.00
60.00	06000	LABORATORY	202,843	58,040,256	0.003495	561,705	1,963	60.00
65.00	06500	RESPIRATORY THERAPY	33,998	9,811,848	0.003465	151,855	526	65.00
66.00	06600	PHYSICAL THERAPY	582,834	13,261,499	0.043949	165,383	7,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,185	1,025,081	0.038226	83,565	3,194	67.00
68.00	06800	SPEECH PATHOLOGY	3,638	555,938	0.006544	25,126	164	68.00
69.00	06900	ELECTROCARDIOLOGY	33,150	14,699,227	0.002255	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	58,396	2,881,905	0.020263	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,147	12,251,229	0.003848	252	1	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	64,815	24,272,634	0.002670	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	157,928	55,628,258	0.002839	847,741	2,407	73.00
74.00	07400	RENAL DIALYSIS	2,590	1,260,800	0.002054	28,900	59	74.00
76.00	03020	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03950	WOUND CARE	53,305	5,127	10.396918	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	66,990	609,405	0.109927	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	459,740	7,062,513	0.065096	0	0	90.00
91.00	09100	EMERGENCY	696,122	79,628,235	0.008742	240,310	2,101	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,929,768	0.000000	5,130	0	92.00
200.00		Total (lines 50 through 199)	6,463,429	479,080,890		2,444,352	20,929	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0304 Component CCN: 14-s304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 8:16 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost 1.00	Nursing School Post-Stepdown Adjustments 2A	Nursing School 2.00	Allied Health Post-Stepdown Adjustments 3A	Allied Health 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	03020 ANCILLARY	0	0	0	0	0	76.00
76.01	03950 WOUND CARE	0	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
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: 14-0304
Component CCN: 14-S304

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	51,117,340	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	0	5,707,939	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	6,025,908	0.000000	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	12,844,005	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	41,714,272	0.000000	54.00
56.00	05600 RADIOISOTOPE	0	0	0	4,864,800	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	50,883,653	0.000000	57.00
58.00	05800 MRI	0	0	0	12,390,700	0.000000	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	4,608,550	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	58,040,256	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	9,811,848	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	13,261,499	0.000000	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	1,025,081	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	555,938	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	14,699,227	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	2,881,905	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,251,229	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,272,634	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	55,628,258	0.000000	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	1,260,800	0.000000	74.00
76.00	03020 ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03950 WOUND CARE	0	0	0	5,127	0.000000	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	0	609,405	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	7,062,513	0.000000	90.00
91.00	09100 EMERGENCY	0	0	0	79,628,235	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,929,768	0.000000	92.00
200.00	Total (lines 50 through 199)	0	0	0	479,080,890		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0304
Component CCN: 14-s304

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

worksheet D
Part IV
Date/Time Prepared:
5/29/2018 8:16 am

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	49,500	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	90,000	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	60,810	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	131,375	0	0	0	57.00
58.00	05800 MRI	0.000000	2,700	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	561,705	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	151,855	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	165,383	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	83,565	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	25,126	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	252	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	847,741	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	28,900	0	0	0	74.00
76.00	03020 ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950 WOUND CARE	0.000000	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	1,530	0	90.00
91.00	09100 EMERGENCY	0.000000	240,310	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,130	0	0	0	92.00
200.00	Total (lines 50 through 199)		2,444,352	0	1,530	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 8:16 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	03020 ANCILLARY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
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: 14-0304 Component CCN: 14-s304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 8:16 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.239525	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.239957	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.661003	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.024937	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147304	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0.189699	0	0	0	56.00
57.00	05700 CT SCAN	0.022368	0	0	0	57.00
58.00	05800 MRI	0.040064	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.234800	0	0	0	59.00
60.00	06000 LABORATORY	0.084868	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.151449	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.482465	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.145963	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.050703	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063441	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.176264	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.609864	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.295002	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.210009	0	0	4,380	73.00
74.00	07400 RENAL DIALYSIS	0.425973	0	0	0	74.00
76.00	03020 ANCILLARY	0.000000	0	0	0	76.00
76.01	03950 WOUND CARE	23.985177	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.558738	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.367023	1,530	0	0	562 90.00
91.00	09100 EMERGENCY	0.100525	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.412578	0	0	0	0 92.00
200.00	Subtotal (see instructions)		1,530	0	4,380	562 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		1,530	0	4,380	562 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/29/2018 8:16 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
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	920	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 ANCILLARY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
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	920	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	920	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0304 Component CCN: 14-s304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/29/2018 8:16 am
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Cost Center Description		Capital Related Cost (from wkst. B, Part II, col. 26)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,735,789	51,117,340	0.033957	0	0	50.00
51.00	05100 RECOVERY ROOM	157,217	5,707,939	0.027544	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	554,595	6,025,908	0.092035	0	0	52.00
53.00	05300 ANESTHESIOLOGY	32,766	12,844,005	0.002551	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	999,186	41,714,272	0.023953	0	0	54.00
56.00	05600 RADIOISOTOPE	298,975	4,864,800	0.061457	0	0	56.00
57.00	05700 CT SCAN	72,491	50,883,653	0.001425	0	0	57.00
58.00	05800 MRI	43,173	12,390,700	0.003484	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	66,556	4,608,550	0.014442	0	0	59.00
60.00	06000 LABORATORY	202,843	58,040,256	0.003495	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	33,998	9,811,848	0.003465	0	0	65.00
66.00	06600 PHYSICAL THERAPY	582,834	13,261,499	0.043949	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	39,185	1,025,081	0.038226	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,638	555,938	0.006544	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	33,150	14,699,227	0.002255	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	58,396	2,881,905	0.020263	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47,147	12,251,229	0.003848	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	64,815	24,272,634	0.002670	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	157,928	55,628,258	0.002839	0	0	73.00
74.00	07400 RENAL DIALYSIS	2,590	1,260,800	0.002054	0	0	74.00
76.00	03020 ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03950 WOUND CARE	53,305	5,127	10.396918	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	66,990	609,405	0.109927	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	459,740	7,062,513	0.065096	0	0	90.00
91.00	09100 EMERGENCY	696,122	79,628,235	0.008742	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,929,768	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	6,463,429	479,080,890		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 8:16 am			
		Component CCN: 14-s304	Title XIX	Subprovider - IPF	TEFRA		
Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03020	ANCILLARY	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	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: 14-0304 Component CCN: 14-s304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 8:16 am				
Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	51,117,340	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,707,939	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,025,908	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,844,005	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	41,714,272	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,864,800	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	50,883,653	0.000000	57.00
58.00	05800	MRI	0	0	0	12,390,700	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,608,550	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	58,040,256	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	9,811,848	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	13,261,499	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,025,081	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	555,938	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,699,227	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,881,905	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	12,251,229	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,272,634	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	55,628,258	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,260,800	0.000000	74.00
76.00	03020	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03950	WOUND CARE	0	0	0	5,127	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	609,405	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	7,062,513	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	79,628,235	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	7,929,768	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	479,080,890		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0304 Component CCN: 14-S304	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/29/2018 8:16 am
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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	03020 ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03950 WOUND CARE	0.000000	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
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: 14-0304
Component CCN: 14-S304

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

Worksheet D
Part IV
Date/Time Prepared:
5/29/2018 8:16 am

Title XIX

Subprovider -
IPF

TEFRA

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	03020 ANCILLARY	0	0	76.00
76.01	03950 WOUND CARE	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
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: 14-0304

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

Worksheet D-1

Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description	Title XVIII	Hospital	PPS
			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,910 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,910 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)		17,290 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)		6,369 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)		18,897,825 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)		18,897,825 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)		18,897,825 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)		903.77 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,756,111 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)		5,756,111 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0304		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1	
Date/Time Prepared: 5/29/2018 8:16 am		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title v & XIX only)	0	0	0.00	0	0	42.00	
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	5,599,975	2,637	2,123.62	873	1,853,920	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)					8,377,571	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					15,987,602	49.00	
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from wkst. D, sum of Parts I and III)					1,030,689	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					499,534	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,530,223	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					14,457,379	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					3,620	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					903.77	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,271,647	89.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304

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

Worksheet D-1

Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description	Cost	Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	2,772,075	18,897,825	0.146688	3,271,647	479,911	90.00
91.00 Nursing School cost	0	18,897,825	0.000000	3,271,647	0	91.00
92.00 Allied health cost	0	18,897,825	0.000000	3,271,647	0	92.00
93.00 All other Medical Education	0	18,897,825	0.000000	3,271,647	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Component CCN: 14-s304		Date/Time Prepared: 5/29/2018 8:16 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)		4,392	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,392	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)		4,392	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		3,588	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)		4,590,020	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)		4,590,020	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)		4,590,020	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)		1,045.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,749,783	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)		3,749,783	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN:14-0304

Period:

Worksheet D-1

Component CCN:14-S304

From 01/01/2017

Date/Time Prepared:

To 12/31/2017

5/29/2018 8:16 am

Title XVIII

Subprovider -

PPS

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	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)					406,831	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					4,156,614	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)					572,178	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					20,929	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					593,107	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,563,507	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: 14-0304	Period: From 01/01/2017 To 12/31/2017	worksheet D-1	
		Component CCN: 14-s304		Date/Time Prepared: 5/29/2018 8:16 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	700,391	4,590,020	0.152590	0	90.00
91.00	Nursing School cost	0	4,590,020	0.000000	0	91.00
92.00	Allied health cost	0	4,590,020	0.000000	0	92.00
93.00	All other Medical Education	0	4,590,020	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN:14-0304 Component CCN:14-s304	Period: From 01/01/2017 To 12/31/2017	worksheet D-1 Date/Time Prepared: 5/29/2018 8:16 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)	4,392	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,392	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)	4,392	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	14	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)	2,775	15.00
16.00	Nursery days (title V or XIX only)	338	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)	4,590,020	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)	4,590,020	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)	4,590,020	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)	1,045.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	14,631	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)	14,631	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0304

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

Worksheet D-1

Component CCN: 14-5304

Date/Time Prepared:
5/29/2018 8:16 am

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(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)					14,631	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)					14,631	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					2	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)					-14,631	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: 14-0304 Component CCN: 14-S304		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/29/2018 8:16 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	4,590,020	0.000000	0	0	90.00
91.00	Nursing School cost	0	4,590,020	0.000000	0	0	91.00
92.00	Allied health cost	0	4,590,020	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,590,020	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3
			Date/Time Prepared: 5/29/2018 8:16 am

Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		6,863,865		30.00
31.00	03100 INTENSIVE CARE UNIT		1,976,620		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	0.239525	3,759,004	900,375	50.00
51.00	05100 RECOVERY ROOM	0.239957	479,127	114,970	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.661003	5,068	3,350	52.00
53.00	05300 ANESTHESIOLOGY	0.024937	1,123,123	28,007	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.147304	2,951,852	434,820	54.00
56.00	05600 RADIOISOTOPE	0.189699	453,619	86,051	56.00
57.00	05700 CT SCAN	0.022368	4,582,126	102,493	57.00
58.00	05800 MRI	0.040064	1,060,466	42,487	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.234800	1,072,539	251,832	59.00
60.00	06000 LABORATORY	0.084868	10,038,429	851,941	60.00
65.00	06500 RESPIRATORY THERAPY	0.151449	3,889,714	589,093	65.00
66.00	06600 PHYSICAL THERAPY	0.482465	783,917	378,213	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.145963	413,866	60,409	67.00
68.00	06800 SPEECH PATHOLOGY	0.050703	338,447	17,160	68.00
69.00	06900 ELECTROCARDIOLOGY	0.063441	2,344,159	148,716	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.176264	67,621	11,919	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.609864	1,486,666	906,664	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.295002	2,558,518	754,768	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.210009	7,516,746	1,578,584	73.00
74.00	07400 RENAL DIALYSIS	0.425973	656,382	279,601	74.00
76.00	03020 ANCILLARY	0.000000	0	0	76.00
76.01	03950 WOUND CARE	23.985177	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.558738	2,946	1,646	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.367023	13,484	4,949	90.00
91.00	09100 EMERGENCY	0.100525	5,790,537	582,094	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.412578	599,715	247,429	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		51,988,071	8,377,571	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)		51,988,071		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	worksheet D-3	
		Component CCN: 14-s304	Date/Time Prepared: 5/29/2018 8:16 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		5,453,760	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.239525	0	50.00
51.00	05100	RECOVERY ROOM	0.239957	49,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.661003	0	52.00
53.00	05300	ANESTHESIOLOGY	0.024937	90,000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.147304	60,810	54.00
56.00	05600	RADIOISOTOPE	0.189699	0	56.00
57.00	05700	CT SCAN	0.022368	131,375	57.00
58.00	05800	MRI	0.040064	2,700	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.234800	0	59.00
60.00	06000	LABORATORY	0.084868	561,705	60.00
65.00	06500	RESPIRATORY THERAPY	0.151449	151,855	65.00
66.00	06600	PHYSICAL THERAPY	0.482465	165,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.145963	83,565	67.00
68.00	06800	SPEECH PATHOLOGY	0.050703	25,126	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063441	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.176264	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.609864	252	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.295002	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210009	847,741	73.00
74.00	07400	RENAL DIALYSIS	0.425973	28,900	74.00
76.00	03020	ANCILLARY	0.000000	0	76.00
76.01	03950	WOUND CARE	23.985177	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.558738	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.367023	0	90.00
91.00	09100	EMERGENCY	0.100525	240,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.412578	5,130	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		2,444,352	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		2,444,352	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 8:16 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)		10,338,275	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,979,480	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)		118,371	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)		103.80	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.78	30.00
31.00	Percentage of Medicaid patient days (see instructions)		28.42	31.00
32.00	Sum of lines 30 and 31		32.20	32.00
33.00	Allowable disproportionate share percentage (see instructions)		15.78	33.00
34.00	Disproportionate share adjustment (see instructions)		564,836	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 8:16 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000175578	0.000166582	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,049,517	1,127,212	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	784,981	284,119	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,069,100		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 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	16,070,062		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)		16,070,062	49.00
50.00	Payment for inpatient program capital (from wkst. L, Pt. I and Pt. II, as applicable)		1,263,950	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		4,143	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 intructions)		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)		17,338,155	59.00
60.00	Primary payer payments		53,263	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		17,284,892	61.00
62.00	Deductibles billed to program beneficiaries		1,485,512	62.00
63.00	Coinsurance billed to program beneficiaries		58,233	63.00
64.00	Allowable bad debts (see instructions)		283,899	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		184,534	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		200,276	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15,925,681	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)		-591	70.93
70.94	HRR adjustment amount (see instructions)		-123,402	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0304

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

Worksheet E
Part A
Date/Time Prepared:
5/29/2018 8:16 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)		Amount	
		0		1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			15,801,688	71.00
71.01	Sequestration adjustment (see instructions)			316,034	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			15,498,092	72.00
73.00	Tentative settlement (for contractor use only)			0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			-12,438	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			492,578	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	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: 14-0304

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

Worksheet DSH

Date/Time Prepared:
5/29/2018 8:16 am

		Title XVIII			Hospital	PPS	
		Original .mcrx 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)	3.78	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	28.42	0.00			28.42	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	32.20	0.00			28.42	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)	103.80	0.00			103.80	5.00
6.00	Disproportionate Share Payment Percentage (transferred from worksheet E, Part A, line 33)	15.78	0.00			12.66	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 greater 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)	3.78	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)	899	0			899	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	1,267	0			1,267	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	7	0			7	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	30	0			30	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	4,120	0			4,120	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	179	0			179	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	6,502	0			6,502	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	22,702	0			22,702	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	175	0			175	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	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)	22,877	0			22,877	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	28.42	0.00			28.42	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet DSH Date/Time Prepared: 5/29/2018 8:16 am
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		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax 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	15.78		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		15.78		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.		15.78		0.00		31.00
		Original .mcrx Values	Adjusted .mcax 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: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet DSH Date/Time Prepared: 5/29/2018 8:16 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	12.66	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	12.66	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.	12.66	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		
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10,338,275	0	10,338,275		10,338,275	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,979,480	0		3,979,480	3,979,480	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	118,371	0	71,971	46,400	118,371	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1578	0.1578	0.1578	0.1578		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	564,836	0	407,845	156,991	564,836	11.00
11.01	Uncompensated care payments	36.00	1,069,100	0	784,981	284,119	1,069,100	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	16,070,062	0	11,603,072	4,466,990	16,070,062	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16,070,062	0	11,603,072	4,466,990	16,070,062	15.00
16.00	Payment for inpatient program capital (from wkst. L, Pt. I, if applicable)	50.00	1,263,950	0	911,676	352,274	1,263,950	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	0	4,143	0	4,143	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0304

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

worksheet E
Part A Exhibit 4
Date/Time Prepared:
5/29/2018 8:16 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	12,518,891	4,819,264	17,338,155	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,161,039	0	836,920	324,119	1,161,039	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	24,657	0	18,348	6,309	24,657	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	0.0674	0.0674	0.0674	0.0674		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	78,254	0	56,408	21,846	78,254	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,263,950	0	911,676	352,274	1,263,950	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to wkst. E, Pt. A.		Y					100.00

		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	10,338,275	10,338,275		10,338,275	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,979,480		3,979,480	3,979,480	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	118,371	71,971	46,400	118,371	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	0.1578	0.1578	0.1578		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	564,836	407,845	156,991	564,836	11.00
11.01	Uncompensated care payments	36.00	1,069,100	784,981	284,119	1,069,100	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	16,070,062	11,603,072	4,466,990	16,070,062	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	16,070,062	11,603,072	4,466,990	16,070,062	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,263,950	911,676	352,274	1,263,950	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	4,143	0	4,143	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			12,518,891	4,819,264	17,338,155	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	1,161,039	836,920	324,119	1,161,039	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	24,657	18,348	6,309	24,657	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0674	0.0674	0.0674		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	78,254	56,408	21,846	78,254	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	1,263,950	911,676	352,274	1,263,950	26.00	
		wkst. E, Pt. A, line	(Amt. from wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	-591	-12,542	11,951	-591	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-123,402	-100,321	-23,081	-123,402	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99			0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	worksheet E Part B Date/Time Prepared: 5/29/2018 8:16 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		12,758	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,562,181	2.00
3.00	OPPS payments		10,488,519	3.00
4.00	Outlier payment (see instructions)		53,064	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)		12,758	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		60,750	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)		60,750	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		60,750	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		47,992	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)		12,758	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)		10,541,583	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)		1,918,604	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)		8,635,737	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)		8,635,737	30.00
31.00	Primary payer payments		2,476	31.00
32.00	Subtotal (line 30 minus line 31)		8,633,261	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)		214,788	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		139,612	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		172,483	36.00
37.00	Subtotal (see instructions)		8,772,873	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-139	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)		8,773,012	40.00
40.01	Sequestration adjustment (see instructions)		175,460	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		8,661,529	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-63,977	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 8:16 am
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 8:16 am
		Component CCN: 14-S304		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		920	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		562	2.00
3.00	OPPS payments		533	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		920	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		4,380	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)		4,380	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		4,380	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		3,460	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		920	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)		533	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)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		1,453	27.00
28.00	Direct graduate medical education payments (from wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,453	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,453	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		1,453	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)		1,453	40.00
40.01	Sequestration adjustment (see instructions)		29	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,810	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-386	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0304	Period: From 01/01/2017	Worksheet E Part B
	Component CCN: 14-s304	To 12/31/2017	Date/Time Prepared: 5/29/2018 8:16 am
	Title XVIII	Subprovider - IPF	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0304

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

Worksheet E-1
Part I
Date/Time Prepared:
5/29/2018 8:16 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		15,531,251		8,682,680		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	10/18/2017	33,159	10/18/2017	21,151		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)		-33,159		-21,151		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)		15,498,092		8,661,529		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0		6.01
6.02	SETTLEMENT TO PROGRAM		12,438		63,977		6.02
7.00	Total Medicare program liability (see instructions)		15,485,654		8,597,552		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0304

Period: From 01/01/2017

Worksheet E-1

Component CCN: 14-S304

To 12/31/2017

Part I

Date/Time Prepared: 5/29/2018 8:16 am

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		3,494,627		1,810	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)		3,494,627		1,810	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		386	6.02
7.00	Total Medicare program liability (see instructions)		3,494,627		1,424	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: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 8:16 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/29/2018 8:16 am
		Component CCN: 14-S304		
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			3,507,881 1.00
2.00	Net IPF PPS Outlier Payments			194,767 2.00
3.00	Net IPF PPS ECT Payments			15,212 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)			12.032877 9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			3,717,860 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)			3,717,860 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			3,717,860 18.00
19.00	Deductibles			139,412 19.00
20.00	Subtotal (line 18 minus line 19)			3,578,448 20.00
21.00	Coinsurance			12,502 21.00
22.00	Subtotal (line 20 minus line 21)			3,565,946 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			3,565,946 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)			3,565,946 31.00
31.01	Sequestration adjustment (see instructions)			71,319 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			3,494,627 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)			0 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			194,767 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: 14-0304

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

Worksheet G

Date/Time Prepared:
5/29/2018 8:16 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	-19,747,623	0	0	0	1.00
2.00	Temporary investments	10,273	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	100,972,343	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-74,222,193	0	0	0	6.00
7.00	Inventory	3,026,853	0	0	0	7.00
8.00	Prepaid expenses	3,240,672	0	0	0	8.00
9.00	Other current assets	0	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)	13,280,325	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,750,000	0	0	0	12.00
13.00	Land improvements	312,035	0	0	0	13.00
14.00	Accumulated depreciation	-108,820	0	0	0	14.00
15.00	Buildings	110,256,662	0	0	0	15.00
16.00	Accumulated depreciation	-37,152,074	0	0	0	16.00
17.00	Leasehold improvements	1,710,040	0	0	0	17.00
18.00	Accumulated depreciation	-1,173,055	0	0	0	18.00
19.00	Fixed equipment	23,136,181	0	0	0	19.00
20.00	Accumulated depreciation	-15,821,600	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	40,768,209	0	0	0	23.00
24.00	Accumulated depreciation	-36,100,898	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)	89,576,680	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,609,435	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	3,144,862	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,754,297	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	107,611,302	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	7,568,088	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,002,309	0	0	0	38.00
39.00	Payroll taxes payable	3,091,888	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	17,207,148	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	28,869,433	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	73,093,412	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	217,230	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	73,310,642	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	102,180,075	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	5,431,227	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)	5,431,227	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	107,611,302	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0304

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

Worksheet G-1

Date/Time Prepared:
5/29/2018 8:16 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		19,625,822		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		2,952,952			2.00
3.00	Total (sum of line 1 and line 2)		22,578,774		0	3.00
4.00	RESTRICTED	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		22,578,774		0	11.00
12.00	UNRESTRICTED NET ASSETS	17,147,547		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		17,147,547		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,431,227		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	RESTRICTED		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	UNRESTRICTED NET ASSETS		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0304

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/29/2018 8:16 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	24,735,511		24,735,511	1.00
2.00	SUBPROVIDER - IPF	6,678,075		6,678,075	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)	31,413,586		31,413,586	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,688,465		5,688,465	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)	5,688,465		5,688,465	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	37,102,051		37,102,051	17.00
18.00	Ancillary services	129,184,858	270,925,474	400,110,332	18.00
19.00	Outpatient services	15,534,449	64,108,301	79,642,750	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	RETAIL PHARMACY	0	556,722	556,722	27.00
27.01	PHYSICIAN REVENUE	0	628,889	628,889	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to wkst. G-3, line 1)	181,821,358	336,219,386	518,040,744	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		128,070,406		29.00
30.00	BAD DEBT	9,455,698			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)		9,455,698		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)		137,526,104		43.00

STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/29/2018 8:16 am
				1.00
1.00	Total patient revenues (from wkst. G-2, Part I, column 3, line 28)		518,040,744	1.00
2.00	Less contractual allowances and discounts on patients' accounts		379,474,101	2.00
3.00	Net patient revenues (line 1 minus line 2)		138,566,643	3.00
4.00	Less total operating expenses (from wkst. G-2, Part II, line 43)		137,526,104	4.00
5.00	Net income from service to patients (line 3 minus line 4)		1,040,539	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		1,912,413	24.00
25.00	Total other income (sum of lines 6-24)		1,912,413	25.00
26.00	Total (line 5 plus line 25)		2,952,952	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)		2,952,952	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0304	Period: From 01/01/2017 To 12/31/2017	worksheet L Parts I-III Date/Time Prepared: 5/29/2018 8:16 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,161,039	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		24,657	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)		55.07	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (worksheet E, part A line 30) (see instructions)		3.78	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		28.42	8.00
9.00	Sum of lines 7 and 8		32.20	9.00
10.00	Allowable disproportionate share percentage (see instructions)		6.74	10.00
11.00	Disproportionate share adjustment (see instructions)		78,254	11.00
12.00	Total prospective capital payments (see instructions)		1,263,950	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