

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: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 4/29/2018 11:23 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: 4/29/2018 Time: 11:23 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 HARTGROVE HOSPITAL (14-4026) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

 Title

 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	17,010	199	0	-4,102,648	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	17,010	199	0	-4,102,648	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: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 4/29/2018 11:22 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 520 N. RIDGEWAY AVE		PO Box:						1.00			
2.00	City: CHI CAGO		State: IL		Zip Code: 60624-		County: COOK		2.00			
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)					
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		HARTGROVE HOSPITAL	144026	16974	4	08/20/1984	N	P	O	3.00	
4.00	Subprovider - IPF										4.00	
5.00	Subprovider - IRF										5.00	
6.00	Subprovider - (Other)										6.00	
7.00	Swing Beds - SNF										7.00	
8.00	Swing Beds - NF										8.00	
9.00	Hospital-Based SNF										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)					4			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.					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)					N	N		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.						2 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.					0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.					0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 4/29/2018 11:22 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)					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	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(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	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

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

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

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						1.00	
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.00	
						V XIX	
						1.00 2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00		97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y		Y		98.06	
Rural Providers							
105.00	Does this hospital qualify as a CAH?	N				105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00	
						Physical Occupational Speech Respiratory	
						1.00 2.00 3.00 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		N		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: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 4/29/2018 11:22 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:	0	0	2,173	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			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		399001	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 4/29/2018 11:22 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: UNIVERSAL HEALTH SERVICES, INC	Contractor's Name: NOVITAS		Contractor's Number: 12001		141.00		
142.00	Street: 367 S. GULPH ROAD	PO Box:				142.00		
143.00	City: KING OF PRUSSIA	State: PA		Zip Code: 19406		143.00		
						1.00		
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00
						1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	146.00
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N			155.00
156.00	Subprovider - IPF	N	N	N	N			156.00
157.00	Subprovider - IRF	N	N	N	N			157.00
158.00	SUBPROVIDER							158.00
159.00	SNF	N	N	N	N			159.00
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00
161.00	CMHC		N	N	N			161.00
						1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
						1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 4/29/2018 11:22 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	03/01/2018	Y	03/01/2018		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)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 4/29/2018 11:22 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DONNA		BRAUNLINGER	41.00
42.00	Enter the employer/company name of the cost report preparer.	UNIVERSAL HEALTH SERVICES, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	610-786-3482		DONNA.BRAUNLINGER@UHSONC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-4026

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

Worksheet S-2
Part II
Date/Time Prepared:
4/29/2018 11:22 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4026

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

Worksheet S-3
Part I
Date/Time Prepared:
4/29/2018 11:22 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	160	58,400	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)		160	58,400	0.00	0	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)		160	58,400	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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)		160				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4026

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

Worksheet S-3
Part I
Date/Time Prepared:
4/29/2018 11:22 am

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)	3,085	11,426	48,378			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	3,085	11,426	48,378			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)	3,085	11,426	48,378	0.00	281.06	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						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	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	281.06	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4026

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

Worksheet S-3
Part I
Date/Time Prepared:
4/29/2018 11:22 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	247	616	4,346	1.00
2.00 HMO and other (see instructions)				0	0		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		247	616	4,346	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4026

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

Worksheet A
Date/Time Prepared:
4/29/2018 11:22 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		1,975,165	1,975,165	24,943	2,000,108	1.00
2.00	00200		482,537	482,537	11,586	494,123	2.00
4.00	00400		4,675,919	4,877,073	0	4,877,073	4.00
5.00	00500	201,154	1,317,113	4,606,679	-620,328	3,986,351	5.00
7.00	00700	254,492	662,034	916,526	0	916,526	7.00
8.00	00800	0	178,930	178,930	0	178,930	8.00
9.00	00900	0	461,971	461,971	0	461,971	9.00
10.00	01000	372,759	809,353	1,182,112	0	1,182,112	10.00
13.00	01300	1,246,985	11,655	1,258,640	0	1,258,640	13.00
16.00	01600	210,951	375,896	586,847	0	586,847	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	8,483,699	2,919,163	11,402,862	-22,431	11,380,431	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	191,152	191,152	0	191,152	60.00
69.00	06900	0	242,745	242,745	0	242,745	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	705,807	705,807	0	705,807	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	972,759	579,080	1,551,839	-1,551,839	0	90.00
93.00	04950	0	0	0	1,026,876	1,026,876	93.00
93.99	09399	0	0	0	524,963	524,963	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		15,032,365	15,588,520	30,620,885	-606,230	30,014,655	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	606,230	606,230	192.01
192.02	19202	190,617	5,406	196,023	0	196,023	192.02
192.03	19203	0	0	0	0	0	192.03
200.00		15,222,982	15,593,926	30,816,908	0	30,816,908	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4026

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

Worksheet A
Date/Time Prepared:
4/29/2018 11:22 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-900	1,999,208	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-21,891	472,232	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-74,647	4,802,426	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,097,641	5,083,992	5.00
7.00	00700	OPERATION OF PLANT	-5,921	910,605	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	178,930	8.00
9.00	00900	HOUSEKEEPING	0	461,971	9.00
10.00	01000	DIETARY	-375	1,181,737	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,258,640	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	586,847	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,330,659	9,049,772	30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	191,152	60.00
69.00	06900	ELECTROCARDIOLOGY	0	242,745	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	705,807	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	-312,653	714,223	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	524,963	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,649,405	28,365,250	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	MARKETING	0	606,230	192.01
192.02	19202	ADOL. EDUCATION	0	196,023	192.02
192.03	19203	N/A MEALS	0	0	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-1,649,405	29,167,503	200.00

RECLASSIFICATIONS

Provider CCN: 14-4026

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

Worksheet A-6

Date/Time Prepared:
4/29/2018 11:22 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - LEASES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	24,943	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,586	2.00	
	TOTALS		0	36,529		
B - MARKETING						
1.00	MARKETING	192.01	558,183	48,047	1.00	
	TOTALS		558,183	48,047		
C - MEDICAL DIRECTOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,431	1.00	
	TOTALS		0	22,431		
D - OUTPATIENT						
1.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	454,526	572,350	1.00	
2.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	518,233	6,730	2.00	
	TOTALS		972,759	579,080		
500.00	Grand Total: Increases		1,530,942	686,087	500.00	

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
	6.00	7.00	8.00	9.00	10.00			
A - LEASES								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	36,529		10		1.00
2.00		0.00	0	0		10		2.00
	TOTALS		0	36,529				
B - MARKETING								
1.00	ADMINISTRATIVE & GENERAL	5.00	558,183	48,047		0		1.00
	TOTALS		558,183	48,047				
C - MEDICAL DIRECTOR								
1.00	ADULTS & PEDIATRICS	30.00	0	22,431		0		1.00
	TOTALS		0	22,431				
D - OUTPATIENT								
1.00	CLINIC	90.00	972,759	579,080		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		972,759	579,080				
500.00	Grand Total: Decreases		1,530,942	686,087				500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4026

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

Worksheet A-7
Part I
Date/Time Prepared:
4/29/2018 11:22 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,243,300	0	0	0	50,000	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	30,168,241	272,425	0	272,425	6,202,950	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	3,922,864	51,580	0	51,580	732,902	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	36,334,405	324,005	0	324,005	6,985,852	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	36,334,405	324,005	0	324,005	6,985,852	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,193,300	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	24,237,716	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	3,241,542	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	29,672,558	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	29,672,558	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4026

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

Worksheet A-7
Part II
Date/Time Prepared:
4/29/2018 11:22 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	981,372	0	0	33,793	960,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	363,448	0	114,667	4,422	0	2.00
3.00	Total (sum of lines 1-2)	1,344,820	0	114,667	38,215	960,000	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	1,975,165				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	482,537				2.00
3.00	Total (sum of lines 1-2)	0	2,457,702				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4026

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

Worksheet A-7
Part III
Date/Time Prepared:
4/29/2018 11:22 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	29,672,558	0	29,672,558	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	29,672,558	0	29,672,558	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	981,372	24,943	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	363,448	11,586	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,344,820	36,529	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	-900	33,793	960,000	0	1,999,208	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	114,667	-17,469	0	0	472,232	2.00
3.00	Total (sum of lines 1-2)	113,767	16,324	960,000	0	2,471,440	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4026

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

Worksheet A-8

Date/Time Prepared:
4/29/2018 11:22 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
				Cost Center	Line #			
				1.00	2.00			3.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-87,851		ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00	Television and radio service (chapter 21)			0		0.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,643,312				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	-247,885				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-375		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			0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines			0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	PHP TRANSPORTATION	A	-240,839		ADMINISTRATIVE & GENERAL	5.00	0	33.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
34.00 DONATIONS	A	-15,378	ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00 MARKETING	A	-71,590	ADMINISTRATIVE & GENERAL	5.00	0 35.00
36.00 LOBBYING OFFSET	A	-12,023	ADMINISTRATIVE & GENERAL	5.00	0 36.00
37.00 MISC ADMIN REVENUE	B	-5,362	ADMINISTRATIVE & GENERAL	5.00	0 37.00
39.00 REBATES	B	87,851	ADMINISTRATIVE & GENERAL	5.00	0 39.00
41.00 INTEREST INCOME FROM PAYORS	B	-238,532	ADMINISTRATIVE & GENERAL	5.00	0 41.00
41.01 PENALTIES	A	-34,858	ADMINISTRATIVE & GENERAL	5.00	0 41.01
41.02 LEGAL FEES	A	-147,876	ADMINISTRATIVE & GENERAL	5.00	0 41.02
41.03 PHP TRANSPORTATION	A	-21,891	CAP REL COSTS-MVBLE EQUIP	2.00	12 41.03
41.04 PHYSICIAN BILLING COSTS	A	-92,024	ADMINISTRATIVE & GENERAL	5.00	0 41.04
41.05 SPORTS TICKETS	A	-66,808	ADMINISTRATIVE & GENERAL	5.00	0 41.05
41.06 BAD DEBTS	A	2,272,428	ADMINISTRATIVE & GENERAL	5.00	0 41.06
41.07 PHP TRANSPORTATION	A	-5,921	OPERATION OF PLANT	7.00	0 41.07
41.08 PHP TRANSPORTATION BENEFITS	A	-77,159	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 41.08
41.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 41.09
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,649,405			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: 14-4026

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

Worksheet A-8-1

Date/Time Prepared:
4/29/2018 11:22 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	H. O. INTEREST	-900	0
2.00	5.00	ADMINISTRATIVE & GENERAL	H. O. MGMNT FEE	1,529,603	1,510,680
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	128,674	126,162
4.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	77,451	345,871
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,734,828	1,982,713

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

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

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

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

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

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

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

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

Provider CCN: 14-4026

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

Worksheet A-8-1

Date/Time Prepared:
4/29/2018 11:22 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	-900	11		1.00
2.00	18,923	0		2.00
3.00	2,512	0		3.00
4.00	-268,420	0		4.00
5.00	-247,885			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	HOSP MGMNT		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-4026

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

Worksheet A-8-2

Date/Time Prepared:
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	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	2,389,058	2,288,535	100,523	181,300	670	1.00
2.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	312,653	312,653	0	181,300	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
200.00			2,701,711	2,601,188	100,523		670	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	58,399	2,920	0	0	0	1.00
2.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	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
200.00			58,399	2,920	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	58,399	42,124	2,330,659		1.00
2.00	93.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	312,653		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	58,399	42,124	2,643,312		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4026

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,999,208	1,999,208			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	472,232		472,232		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,802,426	14,918	3,524	4,820,868	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	5,083,992	204,468	48,297	876,566	5.00
7.00 00700	OPERATION OF PLANT	910,605	347,991	82,199	81,673	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	178,930	0	0	0	8.00
9.00 00900	HOUSEKEEPING	461,971	24,975	5,899	0	9.00
10.00 01000	DIETARY	1,181,737	112,340	26,536	119,627	10.00
13.00 01300	NURSING ADMINISTRATION	1,258,640	12,006	2,836	400,187	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	586,847	18,238	4,308	67,699	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	9,049,772	1,180,348	278,809	2,722,627	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	191,152	2,190	517	0	60.00
69.00 06900	ELECTROCARDIOLOGY	242,745	3,561	841	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	705,807	14,003	3,308	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	714,223	5,991	1,415	145,868	93.00
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM	524,963	45,619	10,776	166,313	93.99
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	28,365,250	1,986,648	469,265	4,580,560	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	MARKETING	606,230	7,387	1,745	179,134	192.01
192.02 19202	ADOL. EDUCATION	196,023	5,173	1,222	61,174	192.02
192.03 19203	N/A MEALS	0	0	0	0	192.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	29,167,503	1,999,208	472,232	4,820,868	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4026

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,213,323				5.00
7.00	00700	OPERATION OF PLANT	385,039	1,807,507			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	48,433	0	227,363		8.00
9.00	00900	HOUSEKEEPING	133,405	31,528	0	657,778	9.00
10.00	01000	DIETARY	389,850	141,815	0	52,525	2,024,430
13.00	01300	NURSING ADMINISTRATION	453,035	15,156	0	5,614	0
16.00	01600	MEDICAL RECORDS & LIBRARY	183,278	23,023	0	8,527	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,581,565	1,490,043	227,363	551,873	1,638,068
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	52,475	2,764	0	1,024	0
69.00	06900	ELECTROCARDIOLOGY	66,899	4,495	0	1,665	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	195,736	17,677	0	6,547	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	234,818	7,563	0	2,801	0
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	202,383	57,588	0	21,329	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,926,916	1,791,652	227,363	651,905	1,638,068
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	MARKETING	215,057	9,325	0	3,454	0
192.02	19202	ADOL. EDUCATION	71,350	6,530	0	2,419	0
192.03	19203	N/A MEALS	0	0	0	0	386,362
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	6,213,323	1,807,507	227,363	657,778	2,024,430

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4026

Period:
From 01/01/2017
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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
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
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	2,147,474					13.00
16.00	01600	0	891,920				16.00
17.00	01700	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,147,474	744,591	0	23,612,533	0	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	4,851	0	254,973	0	60.00
69.00	06900	0	2,688	0	322,894	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	6,040	0	949,118	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
93.00	04950	0	65,698	0	1,178,377	0	93.00
93.99	09399	0	68,052	0	1,097,023	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		2,147,474	891,920	0	27,414,918	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	1,022,332	0	192.01
192.02	19202	0	0	0	343,891	0	192.02
192.03	19203	0	0	0	386,362	0	192.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		2,147,474	891,920	0	29,167,503	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4026

Period:
From 01/01/2017
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
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	30.00
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	MARKETING	192.01
192.02	19202	ADOL. EDUCATION	192.02
192.03	19203	N/A MEALS	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4026

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	2.00	2A	4.00	
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	14,918	3,524	18,442	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	40,973	204,468	48,297	293,738	5.00
7.00 00700	OPERATION OF PLANT	0	347,991	82,199	430,190	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	24,975	5,899	30,874	9.00
10.00 01000	DIETARY	0	112,340	26,536	138,876	10.00
13.00 01300	NURSING ADMINISTRATION	0	12,006	2,836	14,842	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	18,238	4,308	22,546	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	1,180,348	278,809	1,459,157	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0	2,190	517	2,707	60.00
69.00 06900	ELECTROCARDIOLOGY	0	3,561	841	4,402	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	14,003	3,308	17,311	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	5,991	1,415	7,406	93.00
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM	0	45,619	10,776	56,395	93.99
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	40,973	1,986,648	469,265	2,496,886	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	MARKETING	0	7,387	1,745	9,132	192.01
192.02 19202	ADOL. EDUCATION	0	5,173	1,222	6,395	192.02
192.03 19203	N/A MEALS	0	0	0	0	192.03
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)	40,973	1,999,208	472,232	2,512,413	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4026

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	297,092					5.00
7.00	00700	OPERATION OF PLANT	18,411	448,914				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,316	0	2,316			8.00
9.00	00900	HOUSEKEEPING	6,379	7,830	0	45,083		9.00
10.00	01000	DIETARY	18,641	35,221	0	3,600	196,796	10.00
13.00	01300	NURSING ADMINISTRATION	21,662	3,764	0	385	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,764	5,718	0	584	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	171,252	370,070	2,316	37,824	159,237	30.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	2,509	686	0	70	0	60.00
69.00	06900	ELECTROCARDIOLOGY	3,199	1,116	0	114	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,359	4,390	0	449	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	11,228	1,878	0	192	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	9,677	14,303	0	1,462	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	283,397	444,976	2,316	44,680	159,237	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	MARKETING	10,283	2,316	0	237	0	192.01
192.02	19202	ADOL. EDUCATION	3,412	1,622	0	166	0	192.02
192.03	19203	N/A MEALS	0	0	0	0	37,559	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	297,092	448,914	2,316	45,083	196,796	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4026

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

Worksheet B
Part II
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Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	16.00	17.00	24.00	25.00	
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
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
13.00	01300	42,184					13.00
16.00	01600	0	37,871				16.00
17.00	01700	0	0	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	42,184	31,610	0	2,284,064	0	30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	0	206	0	6,178	0	60.00
69.00	06900	0	114	0	8,945	0	69.00
70.00	07000	0	0	0	0	0	70.00
73.00	07300	0	257	0	31,766	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
93.00	04950	0	2,792	0	24,054	0	93.00
93.99	09399	0	2,892	0	85,365	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		42,184	37,871	0	2,440,372	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	22,653	0	192.01
192.02	19202	0	0	0	11,829	0	192.02
192.03	19203	0	0	0	37,559	0	192.03
200.00					0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		42,184	37,871	0	2,512,413	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4026

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

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
13.00	01300	NURSING ADMINISTRATION	13.00
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	30.00
ANCILLARY SERVICE COST CENTERS			
60.00	06000	LABORATORY	60.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	MARKETING	192.01
192.02	19202	ADOL. EDUCATION	192.02
192.03	19203	N/A MEALS	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4026

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

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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	83,090				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		83,090			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	620	620	15,021,828		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,498	8,498	2,731,383	-6,213,323	5.00
7.00 00700	OPERATION OF PLANT	14,463	14,463	254,492	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	1,038	1,038	0	0	9.00
10.00 01000	DIETARY	4,669	4,669	372,759	0	10.00
13.00 01300	NURSING ADMINISTRATION	499	499	1,246,985	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	758	758	210,951	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	49,057	49,057	8,483,699	0	30.00
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	91	91	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	148	148	0	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00 07300	DRUGS CHARGED TO PATIENTS	582	582	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	249	249	454,526	0	93.00
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM	1,896	1,896	518,233	0	93.99
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	82,568	82,568	14,273,028	-6,213,323	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01 19201	MARKETING	307	307	558,183	0	192.01
192.02 19202	ADOL. EDUCATION	215	215	190,617	0	192.02
192.03 19203	N/A MEALS	0	0	0	0	192.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,999,208	472,232	4,820,868	6,213,323	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.060753	5.683379	0.320924	0.270684	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			18,442	297,092	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001228	0.012943	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: 14-4026

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

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Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	NURSING ADMINISTRATION (NURSING NRSING HR)	
		7.00	8.00	9.00	10.00	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	59,509				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	48,378			8.00
9.00	00900	HOUSEKEEPING	1,038	0	58,471		9.00
10.00	01000	DIETARY	4,669	0	4,669	179,366	10.00
13.00	01300	NURSING ADMINISTRATION	499	0	499	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	758	0	758	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	49,057	48,378	49,057	145,134	303,341
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	91	0	91	0	60.00
69.00	06900	ELECTROCARDIOLOGY	148	0	148	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	582	0	582	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	249	0	249	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	1,896	0	1,896	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,987	48,378	57,949	145,134	303,341
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	MARKETING	307	0	307	0	192.01
192.02	19202	ADOL. EDUCATION	215	0	215	0	192.02
192.03	19203	N/A MEALS	0	0	0	34,232	192.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,807,507	227,363	657,778	2,024,430	2,147,474
203.00		Unit cost multiplier (Wkst. B, Part I)	30.373675	4.699719	11.249645	11.286587	7.079406
204.00		Cost to be allocated (per Wkst. B, Part II)	448,914	2,316	45,083	196,796	42,184
205.00		Unit cost multiplier (Wkst. B, Part II)	7.543632	0.047873	0.771032	1.097176	0.139065
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

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Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		16.00	17.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,603,035	16.00
17.00	01700	SOCIAL SERVICE	0 48,378	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	70,627,500	30.00
ANCILLARY SERVICE COST CENTERS				
60.00	06000	LABORATORY	460,177	60.00
69.00	06900	ELECTROCARDIOLOGY	254,990	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	572,967	73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	6,232,066	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	6,455,335	93.99
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	84,603,035	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	MARKETING	0	192.01
192.02	19202	ADOL. EDUCATION	0	192.02
192.03	19203	N/A MEALS	0	192.03
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	891,920	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010542	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	37,871	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000448	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4026

Period:
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Worksheet C
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Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		Total Costs
				1.00	2.00		3.00
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	23,612,533		23,612,533	42,124	23,654,657 30.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	254,973		254,973	0	254,973 60.00	
69.00	06900 ELECTROCARDIOLOGY	322,894		322,894	0	322,894 69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0 70.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	949,118		949,118	0	949,118 73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0 90.00	
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	1,178,377		1,178,377	0	1,178,377 93.00	
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	1,097,023		1,097,023	0	1,097,023 93.99	
200.00	Subtotal (see instructions)	27,414,918	0	27,414,918	42,124	27,457,042 200.00	
201.00	Less Observation Beds	0		0	0	0 201.00	
202.00	Total (see instructions)	27,414,918	0	27,414,918	42,124	27,457,042 202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4026

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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	70,627,500		70,627,500			30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	460,177	0	460,177	0.554076	0.000000	60.00
69.00	06900 ELECTROCARDIOLOGY	254,990	0	254,990	1.266301	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	572,967	0	572,967	1.656497	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0.000000	0.000000	90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0	6,232,066	6,232,066	0.189083	0.000000	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	6,455,335	6,455,335	0.169941	0.000000	93.99
200.00	Subtotal (see instructions)	71,915,634	12,687,401	84,603,035			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	71,915,634	12,687,401	84,603,035			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 4/29/2018 11:22 am
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
	ANCILLARY SERVICE COST CENTERS			
60.00	06000 LABORATORY	0.554076		60.00
69.00	06900 ELECTROCARDIOLOGY	1.266301		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.656497		73.00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.189083		93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.169941		93.99
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: 14-4026

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		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	23,612,533	23,612,533	42,124	23,654,657	30.00
ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	254,973	254,973	0	254,973	60.00
69.00	06900 ELECTROCARDIOLOGY	322,894	322,894	0	322,894	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	949,118	949,118	0	949,118	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	1,178,377	1,178,377	0	1,178,377	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	1,097,023	1,097,023	0	1,097,023	93.99
200.00	Subtotal (see instructions)	27,414,918	27,414,918	42,124	27,457,042	200.00
201.00	Less Observation Beds	0	0	0	0	201.00
202.00	Total (see instructions)	27,414,918	27,414,918	42,124	27,457,042	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4026

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Cost Center Description	Title XIX			Hospital	Cost	TEFRA Inpatient Ratio	
	Charges			Cost or Other Ratio	10.00		
	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	70,627,500		70,627,500		30.00
ANCILLARY SERVICE COST CENTERS							
60.00	06000	LABORATORY	460,177	0	460,177	0.554076	60.00
69.00	06900	ELECTROCARDIOLOGY	254,990	0	254,990	1.266301	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	572,967	0	572,967	1.656497	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	6,232,066	6,232,066	0.189083	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	6,455,335	6,455,335	0.169941	93.99
200.00		Subtotal (see instructions)	71,915,634	12,687,401	84,603,035		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	71,915,634	12,687,401	84,603,035		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 4/29/2018 11:22 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
ANCILLARY SERVICE COST CENTERS				
60.00	06000 LABORATORY	0.000000		60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
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: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 4/29/2018 11:22 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	2,284,064	0	2,284,064	48,378	47.21	30.00
200.00	Total (lines 30 through 199)	2,284,064		2,284,064	48,378		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	3,085	145,643				
200.00	Total (lines 30 through 199)	3,085	145,643				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 4/29/2018 11:22 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		
Title XVIII Hospital PPS								
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	6,178	460,177	0.013425	29,589	397	60.00
69.00	06900	ELECTROCARDIOLOGY	8,945	254,990	0.035080	1,326	47	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,766	572,967	0.055441	52,503	2,911	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	24,054	6,232,066	0.003860	0	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	85,365	6,455,335	0.013224	0	0	93.99
200.00		Total (lines 50 through 199)	156,308	13,975,535		83,418	3,355	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part III Date/Time Prepared: 4/29/2018 11:22 am		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	PPS	
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
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	48,378	0.00	3,085	30.00	
200.00		Total (lines 30 through 199)	0	0	48,378		3,085	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 4/29/2018 11:22 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
60.00 06000 LABORATORY	0	0	0	0	0	60.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	90.00	
93.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00	
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99	
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: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 4/29/2018 11:22 am
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Cost Center Description	Title XVIII			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	460,177	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	254,990	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	572,967	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	6,232,066	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	6,455,335	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	13,975,535		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 4/29/2018 11:22 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								
60.00	06000	LABORATORY	0.000000	29,589	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,326	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	52,503	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	13,407	0	93.99
200.00		Total (lines 50 through 199)		83,418	0	13,407	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 4/29/2018 11:22 am
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Title XVIII		Hospital		PPS			
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	0.554076	0	0	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	1.266301	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.656497	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.189083	0	0	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.169941	13,407	0	0	2,278	93.99
200.00	Subtotal (see instructions)		13,407	0	0	2,278	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		13,407	0	0	2,278	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 4/29/2018 11:22 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-4026

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

Worksheet D
Part V
Date/Time Prepared:
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		Title XIX		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
			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								
60.00	06000	LABORATORY	0.554076	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	1.266301	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.656497	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.189083	0	0	0	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.169941	0	0	0	0	93.99
200.00		Subtotal (see instructions)		0	0	0	0	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)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 4/29/2018 11:22 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 4/29/2018 11:22 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		48,378	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		48,378	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)		48,378	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)		3,085	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)		23,654,657	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)		23,654,657	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)		23,654,657	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)		488.95	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,508,411	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)		1,508,411	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 4/29/2018 11:22 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)					42.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT					43.00
44.00 CORONARY CARE UNIT					44.00
45.00 BURN INTENSIVE CARE UNIT					45.00
46.00 SURGICAL INTENSIVE CARE UNIT					46.00
47.00 OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description					
					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					105,045 48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,613,456 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)					145,643 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,355 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					148,998 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,464,458 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: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 4/29/2018 11:22 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,284,064	23,654,657	0.096559	0	0	90.00
91.00	Nursing School cost	0	23,654,657	0.000000	0	0	91.00
92.00	Allied health cost	0	23,654,657	0.000000	0	0	92.00
93.00	All other Medical Education	0	23,654,657	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 4/29/2018 11:22 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		48,378	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		48,378	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)		48,378	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)		11,426	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)		23,612,533	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)		23,612,533	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)		23,612,533	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)		488.08	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,576,802	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)		5,576,802	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 4/29/2018 11:22 am	
Cost Center Description			Title XIX		Hospital	
			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	
			1.00	2.00	3.00	
			Program Days		Program Cost (col. 3 x col. 4)	
			4.00		5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				359,286	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				5,936,088	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					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: 14-4026		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 4/29/2018 11:22 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,284,064	23,612,533	0.096731	0	0	90.00
91.00	Nursing School cost	0	23,612,533	0.000000	0	0	91.00
92.00	Allied health cost	0	23,612,533	0.000000	0	0	92.00
93.00	All other Medical Education	0	23,612,533	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 4/29/2018 11:22 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		4,501,790		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.554076	29,589	16,395	60.00
69.00	06900 ELECTROCARDIOLOGY	1.266301	1,326	1,679	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.656497	52,503	86,971	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.189083	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.169941	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		83,418	105,045	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)		83,418		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 4/29/2018 11:22 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		16,618,070		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.554076	108,276	59,993	60.00
69.00	06900 ELECTROCARDIOLOGY	1.266301	59,997	75,974	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.656497	134,814	223,319	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.189083	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.169941	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		303,087	359,286	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)		303,087		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 4/29/2018 11:22 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,278	2.00
3.00	OPPS payments		5,240	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		5,240	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		1,195	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)		4,045	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)		4,045	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,045	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)		312	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		203	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		312	36.00
37.00	Subtotal (see instructions)		4,248	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)		4,248	40.00
40.01	Sequestration adjustment (see instructions)		85	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,964	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		199	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-4026

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

Worksheet E-1
Part I
Date/Time Prepared:
4/29/2018 11:22 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		2,308,660		3,964	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	10/18/2017	23,457		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)		23,457		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,332,117		3,964		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		17,010		199		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		2,349,127		4,163		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		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 4/29/2018 11:22 am
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		2,561,920	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		132.542466	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		2,561,920	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		2,561,920	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		2,561,920	18.00
19.00	Deductibles		160,468	19.00
20.00	Subtotal (line 18 minus line 19)		2,401,452	20.00
21.00	Coinsurance		95,599	21.00
22.00	Subtotal (line 20 minus line 21)		2,305,853	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		140,330	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		91,215	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		48,310	25.00
26.00	Subtotal (sum of lines 22 and 24)		2,397,068	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 ADJUSTMENT PS&R		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		2,397,068	31.00
31.01	Sequestration adjustment (see instructions)		47,941	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		2,332,117	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)		17,010	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		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4026	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 4/29/2018 11:22 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		5,936,088		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,936,088	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,936,088	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		15,994,200		8.00
9.00	Ancillary service charges		303,087	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		16,297,287	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		16,297,287	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		10,361,199	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		5,936,088	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,936,088	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,936,088	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		0		34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		5,936,088	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		5,936,088	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		5,936,088	0	40.00
41.00	Interim payments		10,038,736	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-4,102,648	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-4026

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

Worksheet G

Date/Time Prepared:
4/29/2018 11:22 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	-321,939	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,053,903	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	125,903	0	0	0	7.00
8.00	Prepaid expenses	47,456	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)	8,905,323	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,193,300	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	24,389,472	0	0	0	15.00
16.00	Accumulated depreciation	-10,632,586	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	3,985,195	0	0	0	23.00
24.00	Accumulated depreciation	-4,059,397	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)	15,875,984	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	224,177	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	224,177	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,005,484	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	830,254	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,126,649	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	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	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,956,903	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,500,000	0	0	0	47.00
48.00	Unsecured loans	-171,894,729	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-170,394,729	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-166,437,826	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	191,443,310	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)	191,443,310	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,005,484	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4026

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

Worksheet G-1

Date/Time Prepared:
4/29/2018 11:22 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		177,140,693		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		14,302,617			2.00
3.00	Total (sum of line 1 and line 2)		191,443,310		0	3.00
4.00	Additions (credit adjustments) (specify)	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)		191,443,310		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		191,443,310		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			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: 14-4026

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/29/2018 11:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	70,627,500		70,627,500	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
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)	70,627,500		70,627,500	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	70,627,500		70,627,500	17.00
18.00	Ancillary services	1,348,964	0	1,348,964	18.00
19.00	Outpatient services	0	12,687,471	12,687,471	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	71,976,464	12,687,471	84,663,935	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		30,816,908		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	PROFESSIONAL FEES	5,732,793			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)		5,732,793		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		25,084,115		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4026

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

Worksheet G-3

Date/Time Prepared:
4/29/2018 11:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	84,663,935	1.00
2.00	Less contractual allowances and discounts on patients' accounts	45,559,347	2.00
3.00	Net patient revenues (line 1 minus line 2)	39,104,588	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	25,084,115	4.00
5.00	Net income from service to patients (line 3 minus line 4)	14,020,473	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	282,144	24.00
25.00	Total other income (sum of lines 6-24)	282,144	25.00
26.00	Total (line 5 plus line 25)	14,302,617	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)	14,302,617	29.00