

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: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/4/2018 10:56 am
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 5/4/2018 Time: 10:56 am  
 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 6. Date Received: 10. NPR Date:  
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4  
 (2) Settled without Audit 8.  Initial Report for this Provider CCN 12.  If line 5, column 1 is 4: Enter number of times reopened = 0-9.  
 (3) Settled with Audit 9.  Final Report for this Provider CCN  
 (4) Reopened  
 (5) Amended

**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 THE PAVILION FOUNDATION ( 14-4029 ) 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	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	-24,853	27,128	0	-6,584,274	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	-24,853	27,128	0	-6,584,274	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: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/4/2018 10:54 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 809 WEST CHURCH STREET	PO Box:							1.00			
2.00	City: CHAMPAIGN	State: IL		Zip Code: 61820-3999		County: CHAMPAIGN			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	THE PAVILION FOUNDATION		144029	16580	4	07/01/1989	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	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						0	0	0	0	0	25.00

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		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		
<b>Prospective Payment System (PPS)-Capital</b>						
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
<b>Teaching Hospitals</b>						
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.					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) Teaching Hospitals that Claim Residents in Nonprovider Settings						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		
<b>Long Term Care Hospital PPS</b>						
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	
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00	
			V	XIX		
			1.00	2.00		
<b>Title V and XIX Services</b>						
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	N	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	
<b>Rural Providers</b>						
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	N	N
				1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/4/2018 10:54 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		
<b>Miscellaneous Cost Reporting Information</b>						
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	22,189		
		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
<b>Transplant Center Information</b>						
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
<b>All Providers</b>						
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: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 5/4/2018 10:54 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: HIGHMARK		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	
144.00 Are provider based physicians' costs included in Worksheet A?							
						1.00	144.00
						Y	
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							
						1.00	145.00
						N	
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.						146.00
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
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
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	
Multi campus							
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
167.00 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)							
						1.00	170.00
						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	0
							171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 5/4/2018 10:54 am	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
					Y/N		
					1.00		
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			Y	03/01/2018	Y	03/01/2018
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: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/4/2018 10:54 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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
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
<b>Interest Expense</b>					
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
<b>Purchased Services</b>					
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
<b>Provider-Based Physicians</b>					
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	
<b>Home Office Costs</b>					
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	
<b>Cost Report Preparer Contact Information</b>					
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.	610-768-3482		DONNA.BRAUNLINGER@UHSONC.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/4/2018 10:54 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
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: 14-4029

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	69	25,254	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)		69	25,254	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)		69	25,254	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	46.00	34	12,444			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)		103			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-4029

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,833	11,288	20,625			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	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,833	11,288	20,625			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)	1,833	11,288	20,625	0.00	196.46	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			12,435	0.00	0.00	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	196.46	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: 14-4029

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 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	200	975	2,249	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		200	975	2,249	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	0.00					21	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: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet A	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		317,893	317,893	1,527,135	1,845,028	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		195,385	195,385	1,802	197,187	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	153,463	1,837,048	1,990,511	0	1,990,511	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,396,450	3,906,490	5,302,940	-1,395,375	3,907,565	5.00
7.00	00700	OPERATION OF PLANT	178,469	554,979	733,448	0	733,448	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,385	127,385	0	127,385	8.00
9.00	00900	HOUSEKEEPING	166,775	73,104	239,879	0	239,879	9.00
10.00	01000	DIETARY	218,212	527,164	745,376	0	745,376	10.00
13.00	01300	NURSING ADMINISTRATION	196,894	-1,604	195,290	0	195,290	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	64,577	80,941	145,518	0	145,518	16.00
17.00	01700	SOCIAL SERVICE	506,054	10,825	516,879	0	516,879	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,802,520	908,174	3,710,694	-717,550	2,993,144	30.00
46.00	04600	OTHER LONG TERM CARE	1,714,831	179,216	1,894,047	54,000	1,948,047	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
60.00	06000	LABORATORY	0	28,834	28,834	0	28,834	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	293,113	293,113	0	293,113	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	280,203	11,892	292,095	-292,095	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	1,509	1,509	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	453,336	453,336	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,678,448	9,050,839	16,729,287	-367,238	16,362,049	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	SCHOOL	1,129,822	196,747	1,326,569	0	1,326,569	192.01
192.02	19202	MARKETING	0	0	0	326,511	326,511	192.02
192.03	19203	LEASED SPACE	0	0	0	0	0	192.03
192.04	19204	NEW CHOICES - OVERNIGHT	0	0	0	40,727	40,727	192.04
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NON ALLOWABLE MEALS	0	0	0	0	0	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	8,808,270	9,247,586	18,055,856	0	18,055,856	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4029

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

Worksheet A  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,017,223	827,805	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	197,187	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	123,022	2,113,533	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,310,492	2,597,073	5.00
7.00	00700	OPERATION OF PLANT	0	733,448	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,385	8.00
9.00	00900	HOUSEKEEPING	0	239,879	9.00
10.00	01000	DIETARY	-22,407	722,969	10.00
13.00	01300	NURSING ADMINISTRATION	0	195,290	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,731	138,787	16.00
17.00	01700	SOCIAL SERVICE	0	516,879	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-245,202	2,747,942	30.00
46.00	04600	OTHER LONG TERM CARE	-22,621	1,925,426	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
60.00	06000	LABORATORY	0	28,834	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	293,113	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	1,509	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	-7,540	445,796	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,509,194	13,852,855	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	SCHOOL	0	1,326,569	192.01
192.02	19202	MARKETING	0	326,511	192.02
192.03	19203	LEASED SPACE	0	0	192.03
192.04	19204	NEW CHOICES - OVERNIGHT	0	40,727	192.04
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	NON ALLOWABLE MEALS	0	0	193.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,509,194	15,546,662	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - CAPITAL LEASES</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,527,135	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,802	2.00
	TOTALS		0	1,528,937	
<b>B - MEDICAL DIRECTOR/PHYSICIANS</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	460,073	1.00
2.00	OTHER LONG TERM CARE	46.00	0	54,000	2.00
3.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	0	18,000	3.00
	TOTALS		0	532,073	
<b>C - MARKETING</b>					
1.00	MARKETING	192.02	256,985	69,526	1.00
	TOTALS		256,985	69,526	
<b>D - NEW CHOICES OVERNIGHT STAY</b>					
1.00	NEW CHOICES - OVERNIGHT	192.04	39,069	1,658	1.00
	TOTALS		39,069	1,658	
<b>E - PHP RECLASS</b>					
1.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	178,622	6,855	1.00
	TOTALS		178,622	6,855	
<b>F - OP CC RECLASS</b>					
1.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	1,448	61	1.00
2.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	278,755	11,831	2.00
	TOTALS		280,203	11,892	
500.00	Grand Total: Increases		754,879	2,150,941	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - CAPITAL LEASES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,528,937	10		1.00
2.00		0.00	0	0	10		2.00
	TOTALS		0	1,528,937			
<b>B - MEDICAL DIRECTOR/PHYSICIANS</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	532,073	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		0	532,073			
<b>C - MARKETING</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	256,985	69,526	0		1.00
	TOTALS		256,985	69,526			
<b>D - NEW CHOICES OVERNIGHT STAY</b>							
1.00	PARTIAL HOSPITALIZATION PROGRAM	93.99	39,069	1,658	0		1.00
	TOTALS		39,069	1,658			
<b>E - PHP RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	178,622	6,855	0		1.00
	TOTALS		178,622	6,855			
<b>F - OP CC RECLASS</b>							
1.00	CLINIC	90.00	280,203	11,892	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		280,203	11,892			
500.00	Grand Total: Decreases		754,879	2,150,941			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4029

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	475,989	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	7,781,518	7,323,342	0	7,323,342	0	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	1,780,875	578,583	0	578,583	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	10,038,382	7,901,925	0	7,901,925	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	10,038,382	7,901,925	0	7,901,925	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	475,989	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	15,104,860	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	2,359,458	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	17,940,307	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	17,940,307	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4029

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	44,408	273,485	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	177,697	0	0	17,688	0	2.00
3.00	Total (sum of lines 1-2)	177,697	0	0	62,096	273,485	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	317,893				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	195,385				2.00
3.00	Total (sum of lines 1-2)	0	513,278				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4029

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
5/4/2018 10:54 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	17,940,307	0	17,940,307	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)	17,940,307	0	17,940,307	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	0	509,912	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	177,697	1,802	2.00
3.00	Total (sum of lines 1-2)	0	0	0	177,697	511,714	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	0	44,408	273,485	0	827,805	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,688	0	0	197,187	2.00
3.00	Total (sum of lines 1-2)	0	62,096	273,485	0	1,024,992	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4029

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

Worksheet A-8

Date/Time Prepared:  
5/4/2018 10:54 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - 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	-53,591		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	-275,363				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	-999,062				0 12.00
13.00	Laundry and linen service			0		0.00	0 13.00
14.00	Cafeteria-employees and guests	B	-22,407		DIETARY	10.00	0 14.00
15.00	Rental of quarters to employee and others			0		0.00	0 15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0 16.00
17.00	Sale of drugs to other than patients			0		0.00	0 17.00
18.00	Sale of medical records and abstracts	B	-6,731		MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0 19.00
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	LOBBYING	A	-2,662		ADMINISTRATIVE & GENERAL	5.00	0 33.00

Provider CCN: 14-4029  
 Period: From 01/01/2017 To 12/31/2017  
 Worksheet A-8  
 Date/Time Prepared: 5/4/2018 10:54 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		
33.01 BUSINESS INTERRUPTION INSURANCE	B	-268,915	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 MARKETING	A	-14,106	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 PHYSICIAN RECRUITING	A	-5,404	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 ADMIN MISC	A	-273	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 PHYSICIAN BILLING COST	A	-56,743	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 PENALTIES	A	-17,259	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 BAD DEBTS	A	-393,340	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 REBATES	B	53,591	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.09
33.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.10
34.00 MISC, INCOME	B	-37,037	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
36.00 PATIENT TRANSPORTATION	A	-409,892	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.01
37.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,509,194				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: 14-4029  
 Period: From 01/01/2017 To 12/31/2017  
 Worksheet A-8-1  
 Date/Time Prepared: 5/4/2018 10:54 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	854,175	764,108 1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMP	182,666	59,644 2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	15,204	210,132 3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	RIVER OAKS CAPITAL	503,627	1,520,850 4.00
4.01	0.00			0	0 4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,555,672	2,554,734 5.00

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

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

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

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

6.00	B		0.00	UHS INC	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: 14-4029

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

Worksheet A-8-1

Date/Time Prepared:  
5/4/2018 10:54 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	90,067	0		1.00
2.00	123,022	0		2.00
3.00	-194,928	0		3.00
4.00	-1,017,223	10		4.00
4.01	0	0		4.01
5.00	-999,062			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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 MGMT		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: 14-4029

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

Worksheet A-8-2

Date/Time Prepared:  
5/4/2018 10:54 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	255,662	237,662	18,000	181,300	120	1.00
2.00	46.00	OTHER LONG TERM CARE	54,000	0	54,000	181,300	360	2.00
3.00	93.99	PARTIAL HOSPITALIZATION PROGRAM	18,000	0	18,000	181,300	120	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			327,662	237,662	90,000		600	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	10,460	523	0	0	0	1.00
2.00	46.00	OTHER LONG TERM CARE	31,379	1,569	0	0	0	2.00
3.00	93.99	PARTIAL HOSPITALIZATION PROGRAM	10,460	523	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			52,299	2,615	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	10,460	7,540	245,202		1.00
2.00	46.00	OTHER LONG TERM CARE	0	31,379	22,621	22,621		2.00
3.00	93.99	PARTIAL HOSPITALIZATION PROGRAM	0	10,460	7,540	7,540		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	52,299	37,701	275,363		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4029

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	827,805	827,805			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	197,187		197,187		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,113,533	0	0	2,113,533	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,597,073	266,741	63,539	278,261	3,205,614
7.00 00700	OPERATION OF PLANT	733,448	3,008	717	43,583	780,756
8.00 00800	LAUNDRY & LINEN SERVICE	127,385	251	60	0	127,696
9.00 00900	HOUSEKEEPING	239,879	3,343	796	40,727	284,745
10.00 01000	DIETARY	722,969	18,871	4,495	53,288	799,623
13.00 01300	NURSING ADMINISTRATION	195,290	0	0	48,082	243,372
16.00 01600	MEDICAL RECORDS & LIBRARY	138,787	6,245	1,488	15,770	162,290
17.00 01700	SOCIAL SERVICE	516,879	7,643	1,821	123,580	649,923
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	2,747,942	216,799	51,643	640,765	3,657,149
46.00 04600	OTHER LONG TERM CARE	1,925,426	86,045	20,496	418,767	2,450,734
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	28,834	0	0	0	28,834
73.00 07300	DRUGS CHARGED TO PATIENTS	293,113	2,697	642	0	296,452
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	1,509	122	29	354	2,014
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM	445,796	22,852	5,443	102,152	576,243
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	13,852,855	634,617	151,169	1,765,329	13,265,445
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	912	217	0	1,129
192.01 19201	SCHOOL	1,326,569	183,630	43,742	275,906	1,829,847
192.02 19202	MARKETING	326,511	912	217	62,757	390,397
192.03 19203	LEASED SPACE	0	0	0	0	0
192.04 19204	NEW CHOICES - OVERNIGHT	40,727	7,734	1,842	9,541	59,844
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.01 19301	NON ALLOWABLE MEALS	0	0	0	0	0
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	15,546,662	827,805	197,187	2,113,533	15,546,662

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4029

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

Worksheet B  
Part I  
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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	3,205,614					5.00
7.00	00700	202,803	983,559				7.00
8.00	00800	33,169	442	161,307			8.00
9.00	00900	73,963	5,891	0	364,599		9.00
10.00	01000	207,704	33,260	0	12,409	1,052,996	10.00
13.00	01300	63,216	0	0	0	0	13.00
16.00	01600	42,155	11,006	0	4,106	0	16.00
17.00	01700	168,819	13,470	0	5,026	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	949,955	382,105	89,789	142,563	482,856	30.00
46.00	04600	636,583	151,653	54,135	56,581	291,118	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	7,490	0	0	0	0	60.00
73.00	07300	77,004	4,753	0	1,773	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
93.00	04950	523	214	0	80	0	93.00
93.99	09399	149,680	40,276	0	15,027	0	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		2,613,064	643,070	143,924	237,565	773,974	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	293	1,607	0	599	0	192.00
192.01	19201	475,306	323,644	0	120,750	133,303	192.01
192.02	19202	101,406	1,607	0	599	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	15,545	13,631	17,383	5,086	145,719	192.04
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,205,614	983,559	161,307	364,599	1,052,996	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4029

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	306,588					13.00
16.00	01600	0	219,557				16.00
17.00	01700	0	0	837,238			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	190,204	147,228	466,036	6,507,885	0	30.00
46.00	04600	116,384	47,159	280,977	4,085,324	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	1,935	0	38,259	0	60.00
73.00	07300	0	3,920	0	383,902	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
93.00	04950	0	100	0	2,931	0	93.00
93.99	09399	0	19,215	0	800,441	0	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		306,588	219,557	747,013	11,818,742	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	3,628	0	192.00
192.01	19201	0	0	0	2,882,850	0	192.01
192.02	19202	0	0	0	494,009	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	90,225	347,433	0	192.04
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
200.00					0		200.00
201.00		0	0	0	0	0	201.00
202.00		306,588	219,557	837,238	15,546,662	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4029

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

Worksheet B  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
60.00	06000	LABORATORY	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SCHOOL	192.01
192.02	19202	MARKETING	192.02
192.03	19203	LEASED SPACE	192.03
192.04	19204	NEW CHOICES - OVERNIGHT	192.04
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	NON ALLOWABLE MEALS	193.01
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: 14-4029

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/4/2018 10:54 am

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	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	22,880	266,741	63,539	353,160	5.00
7.00 00700	OPERATION OF PLANT	0	3,008	717	3,725	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	251	60	311	8.00
9.00 00900	HOUSEKEEPING	0	3,343	796	4,139	9.00
10.00 01000	DIETARY	0	18,871	4,495	23,366	10.00
13.00 01300	NURSING ADMINISTRATION	0	0	0	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	6,245	1,488	7,733	16.00
17.00 01700	SOCIAL SERVICE	0	7,643	1,821	9,464	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	216,799	51,643	268,442	30.00
46.00 04600	OTHER LONG TERM CARE	0	86,045	20,496	106,541	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	0	0	0	0	60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	2,697	642	3,339	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0	122	29	151	93.00
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM	0	22,852	5,443	28,295	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	22,880	634,617	151,169	808,666	118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	912	217	1,129	192.00
192.01 19201	SCHOOL	0	183,630	43,742	227,372	192.01
192.02 19202	MARKETING	0	912	217	1,129	192.02
192.03 19203	LEASED SPACE	0	0	0	0	192.03
192.04 19204	NEW CHOICES - OVERNIGHT	0	7,734	1,842	9,576	192.04
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.01 19301	NON ALLOWABLE MEALS	0	0	0	0	193.01
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)	22,880	827,805	197,187	1,047,872	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4029

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	353,160					5.00
7.00	00700	22,343	26,068				7.00
8.00	00800	3,654	12	3,977			8.00
9.00	00900	8,149	156	0	12,444		9.00
10.00	01000	22,883	882	0	424	47,555	10.00
13.00	01300	6,965	0	0	0	0	13.00
16.00	01600	4,644	292	0	140	0	16.00
17.00	01700	18,599	357	0	172	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	104,651	10,126	2,213	4,865	21,807	30.00
46.00	04600	70,133	4,019	1,335	1,931	13,147	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	825	0	0	0	0	60.00
73.00	07300	8,484	126	0	61	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
93.00	04950	58	6	0	3	0	93.00
93.99	09399	16,490	1,067	0	513	0	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		287,878	17,043	3,548	8,109	34,954	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	32	43	0	20	0	192.00
192.01	19201	52,365	8,578	0	4,121	6,020	192.01
192.02	19202	11,172	43	0	20	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	1,713	361	429	174	6,581	192.04
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		353,160	26,068	3,977	12,444	47,555	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet B Part II Date/Time Prepared: 5/4/2018 10:54 am	
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	
<b>GENERAL SERVICE COST CENTERS</b>							
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	6,965					13.00
16.00	01600	0	12,809				16.00
17.00	01700	0	0	28,592			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4,321	8,590	15,916	440,931	0	30.00
46.00	04600	2,644	2,750	9,595	212,095	0	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	113	0	938	0	60.00
73.00	07300	0	229	0	12,239	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
93.00	04950	0	6	0	224	0	93.00
93.99	09399	0	1,121	0	47,486	0	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		6,965	12,809	25,511	713,913	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	0	0	0	1,224	0	192.00
192.01	19201	0	0	0	298,456	0	192.01
192.02	19202	0	0	0	12,364	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	0	0	3,081	21,915	0	192.04
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
200.00					0		200.00
201.00		0	0	0	0	0	201.00
202.00		6,965	12,809	28,592	1,047,872	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4029

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

Worksheet B  
Part II  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
46.00	04600	OTHER LONG TERM CARE	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
60.00	06000	LABORATORY	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SCHOOL	192.01
192.02	19202	MARKETING	192.02
192.03	19203	LEASED SPACE	192.03
192.04	19204	NEW CHOICES - OVERNIGHT	192.04
193.00	19300	NONPAID WORKERS	193.00
193.01	19301	NON ALLOWABLE MEALS	193.01
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: 14-4029

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

Worksheet B-1  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	108,963				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		108,963			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,654,807		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	35,111	35,111	1,139,465	-3,205,614	12,341,048 5.00
7.00 00700	OPERATION OF PLANT	396	396	178,469	0	780,756 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	33	33	0	0	127,696 8.00
9.00 00900	HOUSEKEEPING	440	440	166,775	0	284,745 9.00
10.00 01000	DIETARY	2,484	2,484	218,212	0	799,623 10.00
13.00 01300	NURSING ADMINISTRATION	0	0	196,894	0	243,372 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	822	822	64,577	0	162,290 16.00
17.00 01700	SOCIAL SERVICE	1,006	1,006	506,054	0	649,923 17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	28,537	28,537	2,623,898	0	3,657,149 30.00
46.00 04600	OTHER LONG TERM CARE	11,326	11,326	1,714,831	0	2,450,734 46.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
60.00 06000	LABORATORY	0	0	0	0	28,834 60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	355	355	0	0	296,452 73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0 90.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	16	16	1,448	0	2,014 93.00
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM	3,008	3,008	418,308	0	576,243 93.99
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	83,534	83,534	7,228,931	-3,205,614	10,059,831 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	120	120	0	0	1,129 192.00
192.01 19201	SCHOOL	24,171	24,171	1,129,822	0	1,829,847 192.01
192.02 19202	MARKETING	120	120	256,985	0	390,397 192.02
192.03 19203	LEASED SPACE	0	0	0	0	0 192.03
192.04 19204	NEW CHOICES - OVERNIGHT	1,018	1,018	39,069	0	59,844 192.04
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.01 19301	NON ALLOWABLE MEALS	0	0	0	0	0 193.01
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)	827,805	197,187	2,113,533		3,205,614 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.597120	1.809669	0.244203		0.259752 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0		353,160 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.028617 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: 14-4029

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

Worksheet B-1

Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS)	NURSING ADMINISTRATION (NURSING SALARIES)	
		7.00	8.00	9.00	10.00	13.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700	73,456					7.00
8.00	00800	33	37,053				8.00
9.00	00900	440	0	72,983			9.00
10.00	01000	2,484	0	2,484	134,935		10.00
13.00	01300	0	0	0	0	4,517,351	13.00
16.00	01600	822	0	822	0	0	16.00
17.00	01700	1,006	0	1,006	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	28,537	20,625	28,537	61,875	2,802,520	30.00
46.00	04600	11,326	12,435	11,326	37,305	1,714,831	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
60.00	06000	0	0	0	0	0	60.00
73.00	07300	355	0	355	0	0	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
93.00	04950	16	0	16	0	0	93.00
93.99	09399	3,008	0	3,008	0	0	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>							
118.00		48,027	33,060	47,554	99,180	4,517,351	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
192.00	19200	120	0	120	0	0	192.00
192.01	19201	24,171	0	24,171	17,082	0	192.01
192.02	19202	120	0	120	0	0	192.02
192.03	19203	0	0	0	0	0	192.03
192.04	19204	1,018	3,993	1,018	18,673	0	192.04
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
200.00							200.00
201.00							201.00
202.00		983,559	161,307	364,599	1,052,996	306,588	202.00
203.00		13.389771	4.353413	4.995670	7.803728	0.067869	203.00
204.00		26,068	3,977	12,444	47,555	6,965	204.00
205.00		0.354879	0.107333	0.170505	0.352429	0.001542	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4029

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

Worksheet B-1

Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
		16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>				
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	44,928,547	16.00
17.00	01700	SOCIAL SERVICE	0 37,053	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	30,128,481	30.00
46.00	04600	OTHER LONG TERM CARE	9,649,812	46.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
60.00	06000	LABORATORY	395,931	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	802,127	73.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	90.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	20,423	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	3,931,773	93.99
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,928,547	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	SCHOOL	0	192.01
192.02	19202	MARKETING	0	192.02
192.03	19203	LEASED SPACE	0	192.03
192.04	19204	NEW CHOICES - OVERNIGHT	0	192.04
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	NON ALLOWABLE MEALS	0	193.01
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)	219,557	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004887	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	12,809	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000285	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: 14-4029

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,507,885		6,507,885	7,540	6,515,425
46.00	04600 OTHER LONG TERM CARE	4,085,324		4,085,324	22,621	4,107,945
ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	38,259		38,259	0	38,259
73.00	07300 DRUGS CHARGED TO PATIENTS	383,902		383,902	0	383,902
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	2,931		2,931	0	2,931
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	800,441		800,441	7,540	807,981
200.00	Subtotal (see instructions)	11,818,742	0	11,818,742	37,701	11,856,443
201.00	Less Observation Beds	0		0		0
202.00	Total (see instructions)	11,818,742	0	11,818,742	37,701	11,856,443

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4029

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
6.00	7.00	8.00	9.00	10.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,128,481		30,128,481			30.00
46.00	04600	OTHER LONG TERM CARE	9,649,812		9,649,812			46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	395,931	0	395,931	0.096630	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	802,127	0	802,127	0.478605	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	20,423	20,423	0.143515	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	3,931,773	3,931,773	0.203583	0.000000	93.99
200.00		Subtotal (see instructions)	40,976,351	3,952,196	44,928,547			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,976,351	3,952,196	44,928,547			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/4/2018 10:54 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
60.00	06000 LABORATORY	0.096630		60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.478605		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.143515		93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.205500		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: 14-4029

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

Worksheet C  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	6,507,885		6,507,885	7,540	6,515,425
46.00	04600 OTHER LONG TERM CARE	4,085,324		4,085,324	22,621	4,107,945
ANCILLARY SERVICE COST CENTERS						
60.00	06000 LABORATORY	38,259		38,259	0	38,259
73.00	07300 DRUGS CHARGED TO PATIENTS	383,902		383,902	0	383,902
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	2,931		2,931	0	2,931
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	800,441		800,441	7,540	807,981
200.00	Subtotal (see instructions)	11,818,742	0	11,818,742	37,701	11,856,443
201.00	Less Observation Beds	0		0		0
202.00	Total (see instructions)	11,818,742	0	11,818,742	37,701	11,856,443

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 5/4/2018 10:54 am	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,128,481		30,128,481			30.00
46.00	04600	OTHER LONG TERM CARE	9,649,812		9,649,812			46.00
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	395,931	0	395,931	0.096630	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	802,127	0	802,127	0.478605	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	20,423	20,423	0.143515	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	3,931,773	3,931,773	0.203583	0.000000	93.99
200.00		Subtotal (see instructions)	40,976,351	3,952,196	44,928,547			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,976,351	3,952,196	44,928,547			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/4/2018 10:54 am
		Title XIX	Hospital	Cost
Cost Center Description		PPS Inpatient Ratio		
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS			30.00
46.00	04600 OTHER LONG TERM CARE			46.00
	ANCILLARY SERVICE COST CENTERS			
60.00	06000 LABORATORY	0.000000		60.00
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: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 5/4/2018 10:54 am	
		Title XVIII		Hospital		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	440,931	0	440,931	20,625	21.38	30.00
200.00	Total (lines 30 through 199)	440,931		440,931	20,625		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,833	39,190				
200.00	Total (lines 30 through 199)	1,833	39,190				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 5/4/2018 10:54 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)	Hospital Inpatient Program Charges	PPS Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	938	395,931	0.002369	59,329	141	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12,239	802,127	0.015258	135,718	2,071	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	224	20,423	0.010968	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	47,486	3,931,773	0.012078	0	0	93.99
200.00	Total (lines 50 through 199)	60,887	5,150,254		195,047	2,212	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part III Date/Time Prepared: 5/4/2018 10:54 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	20,625	0.00	1,833	30.00	
200.00		Total (lines 30 through 199)	0	0	20,625		1,833	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: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/4/2018 10:54 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	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
93.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	0	93.00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0	93.99
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-4029

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

Worksheet D  
Part IV  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
60.00	06000	LABORATORY	0	0	0	395,931	0.000000	60.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	802,127	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	20,423	0.000000	93.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	3,931,773	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	5,150,254		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 5/4/2018 10:54 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
60.00	06000 LABORATORY	0.000000	59,329	0	0	0	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	135,718	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	601,743	0	93.99
200.00	Total (lines 50 through 199)		195,047	0	601,743	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/4/2018 10:54 am
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
60.00 06000	LABORATORY	0.096630	0	0	0	60.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0.478605	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0.000000	0	0	0	90.00
93.00 04950	OTHER OUTPATIENT SERVICE COST CENTER	0.143515	0	0	0	93.00
93.99 09399	PARTIAL HOSPITALIZATION PROGRAM	0.203583	601,743	0	122,505	93.99
200.00	Subtotal (see instructions)		601,743	0	122,505	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		601,743	0	122,505	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/4/2018 10:54 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
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		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: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/4/2018 10:54 am
	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	0.096630	0	0	0	0	0	60.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.478605	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.000000	0	0	0	0	0	90.00
93.00 04950 OTHER OUTPATIENT SERVICE COST CENTER	0.143515	0	0	0	0	0	93.00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0.203583	0	0	0	0	0	93.99
200.00 Subtotal (see instructions)		0	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	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 5/4/2018 10:54 am
	Title XIX	Hospital	Cost

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
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		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/4/2018 10:54 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,625	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,625	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)		20,625	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)		1,833	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
<b>SWING BED ADJUSTMENT</b>				
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)		6,515,425	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)		6,515,425	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		6,515,425	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		315.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		579,045	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)		579,045	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/4/2018 10:54 am	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					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)				70,688	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				649,733	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)				39,190	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				2,212	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				41,402	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				608,331	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: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/4/2018 10:54 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	440,931	6,515,425	0.067675	0	0	90.00
91.00	Nursing School cost	0	6,515,425	0.000000	0	0	91.00
92.00	Allied health cost	0	6,515,425	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,515,425	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/4/2018 10:54 am
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		20,625	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		20,625	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)		20,625	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)		11,288	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
<b>SWING BED ADJUSTMENT</b>				
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)		6,507,885	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)		6,507,885	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		6,507,885	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		315.53	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,561,703	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,561,703	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/4/2018 10:54 am
Cost Center Description			Title XIX	Hospital	Cost
	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)				238,740 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,800,443 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: 14-4029		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 5/4/2018 10:54 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	440,931	6,507,885	0.067753	0	0	90.00
91.00	Nursing School cost	0	6,507,885	0.000000	0	0	91.00
92.00	Allied health cost	0	6,507,885	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,507,885	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/4/2018 10:54 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		2,678,639		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.096630	59,329	5,733	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.478605	135,718	64,955	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.143515	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.205500	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		195,047	70,688	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)		195,047		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 5/4/2018 10:54 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		17,134,995		30.00
ANCILLARY SERVICE COST CENTERS					
60.00	06000 LABORATORY	0.096630	225,253	21,766	60.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.478605	453,346	216,974	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
93.00	04950 OTHER OUTPATIENT SERVICE COST CENTER	0.143515	0	0	93.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.203583	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		678,599	238,740	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)		678,599		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/4/2018 10:54 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		122,505	2.00
3.00	OPPS payments		221,629	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
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
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
<b>Customary charges</b>				
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)		221,629	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		44,419	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)		177,210	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)		177,210	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		177,210	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		42,587	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		27,682	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		38,791	36.00
37.00	Subtotal (see instructions)		204,892	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)		204,892	40.00
40.01	Sequestration adjustment (see instructions)		4,098	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		173,666	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		27,128	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 14-4029

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
5/4/2018 10:54 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		1,306,599		173,666		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	10,567		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)		10,567		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,317,166		173,666		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		27,128		6.01
6.02	SETTLEMENT TO PROGRAM		24,853		0		6.02
7.00	Total Medicare program liability (see instructions)		1,292,313		200,794		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: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/4/2018 10:54 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,476,008	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)		56.506849	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)		1,476,008	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)		1,476,008	16.00
17.00	Primary payer payments		3,354	17.00
18.00	Subtotal (line 16 less line 17).		1,472,654	18.00
19.00	Deductibles		178,864	19.00
20.00	Subtotal (line 18 minus line 19)		1,293,790	20.00
21.00	Coinsurance		1,974	21.00
22.00	Subtotal (line 20 minus line 21)		1,291,816	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		41,340	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		26,871	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,104	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,318,687	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,318,687	31.00
31.01	Sequestration adjustment (see instructions)		26,374	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		1,317,166	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)		-24,853	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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: 14-4029	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/4/2018 10:54 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		3,800,443		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)		3,800,443	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)		3,800,443	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		17,134,995		8.00
9.00	Ancillary service charges		678,599	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)		17,813,594	0	12.00
<b>CUSTOMARY CHARGES</b>					
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)		17,813,594	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		14,013,151	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)		3,800,443	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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)		3,800,443	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
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)		3,800,443	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)		3,800,443	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		37.00
38.00	Subtotal (line 36 ± line 37)		3,800,443	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)		3,800,443	0	40.00
41.00	Interim payments		10,384,717	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		-6,584,274	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: 14-4029

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

Worksheet G

Date/Time Prepared:  
5/4/2018 10:54 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-32,842	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	4,981,700	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	51,227	0	0	0	7.00
8.00	Prepaid expenses	20,285	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)	5,020,370	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	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	0	0	0	0	15.00
16.00	Accumulated depreciation	0	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	2,478,459	0	0	0	23.00
24.00	Accumulated depreciation	-1,648,020	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)	830,439	0	0	0	30.00
<b>OTHER ASSETS</b>						
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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	5,850,809	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	392,342	0	0	0	37.00
38.00	Salaries, wages, and fees payable	972,480	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	-84,666,355	0	0	0	43.00
44.00	Other current liabilities	860,503	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-82,441,030	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-82,441,030	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	88,291,839	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)	88,291,839	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	5,850,809	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4029

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

Worksheet G-1

Date/Time Prepared:  
5/4/2018 10:54 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		79,340,308		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,951,533			2.00
3.00	Total (sum of line 1 and line 2)		88,291,841		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)		88,291,841		0	11.00
12.00	CONSOLIDATING ENTRIES	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)		88,291,841		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	CONSOLIDATING ENTRIES		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: 14-4029

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
5/4/2018 10:54 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	30,128,481		30,128,481	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	9,649,812		9,649,812	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	39,778,293		39,778,293	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)	39,778,293		39,778,293	17.00
18.00	Ancillary services	1,198,058		1,198,058	18.00
19.00	Outpatient services	0	3,952,196	3,952,196	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)	40,976,351	3,952,196	44,928,547	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,055,856		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 REVENUE	1,694,901			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)		1,694,901		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,360,955		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4029

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

Worksheet G-3

Date/Time Prepared:  
5/4/2018 10:54 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	44,928,547	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,568,543	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,360,004	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,360,955	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,999,049	5.00
<b>OTHER INCOME</b>			
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	2,952,484	24.00
24.01	OTHER (SPECIFY)	0	24.01
25.00	Total other income (sum of lines 6-24)	2,952,484	25.00
26.00	Total (line 5 plus line 25)	8,951,533	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)	8,951,533	29.00