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: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/25/2018 9:52 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2018 Time: 9:52 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PROCTOR HOSPITAL (14-0013) 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	65,079	79,049	0	0	1.00
2.00	Subprovider - IPF	0	36,083	-749		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	6,665	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	107,827	78,300	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 8:42 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 5409 N. KNOXVILLE	PO Box:			1.00
2.00	City: PEORIA	State: IL	Zip Code: 61614	County: PEORIA	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PROCTOR HOSPITAL	140013	37900	1	08/01/1996	N	P	P	3.00
4.00	Subprovider - IPF	PROCTOR HOSPITAL	14S013	37900	4	11/30/2012	N	P	P	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	PROCTOR HOSPITAL	145579	37900		11/03/1987	N	P	P	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: 1.00	To: 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)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	812	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 8:42 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
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.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 8:42 am

		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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	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
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 8:42 am

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2018 8:42 am

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	705,379	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0721	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/25/2018 8:42 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: PEORIA HOME OFFICE	Contractor's Name: NGS		Contractor's Number: 00131	141.00
142.00	Street: 221 NE GLEN OAK	PO Box:			142.00
143.00	City: PEORIA	State: IL		Zip Code: 61636	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	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

		Beginning	Ending	
		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)	10/01/2017	12/29/2017	170.00

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2018 8:42 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.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	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.			Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/10/2018	Y	05/10/2018 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

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		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEITH	LYONS	41.00
42.00	Enter the employer/company name of the cost report preparer.	UNITYPOINT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-672-4281	KEITH.LYONS@UNITYPOINT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/25/2018 8:42 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR REIMBURSEMENT ANALYST		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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2018 8:42 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	94	34,310	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)		94	34,310	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	16	5,840	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		110	40,150	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	18	6,570		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	25	9,125		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	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)		153				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

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,648	776	10,723			1.00
2.00	HMO and other (see instructions)	2,734	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,648	776	10,723			7.00
8.00	INTENSIVE CARE UNIT	707	36	1,397			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		0	0			13.00
14.00	Total (see instructions)	6,355	812	12,120	0.00	525.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,438	0	3,762	0.00	27.94	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	3,701	0	6,278	0.00	28.69	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	582.53	27.00
28.00	Observation Bed Days		272	3,048			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			44			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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2018 8:42 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,590	186	3,224	1.00
2.00	HMO and other (see instructions)			642	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,590	186	3,224	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	195	0	308	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2018 8:42 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	29,827,203	-317,086	29,510,117	1,186,206.00	24.88	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		32,609	0	32,609	45.00	724.64	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,354,595	-701,463	653,132	28,733.00	22.73	9.00
10.00	Excluded area salaries (see instructions)		3,656,525	227,951	3,884,476	178,009.00	21.82	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,444,728	0	1,444,728	33,759.00	42.80	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		20,978	0	20,978	377.00	55.64	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,653,774	0	6,653,774	198,461.00	33.53	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		28,741	0	28,741	210.00	136.86	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		7,892,580	0	7,892,580			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,610,006	0	1,610,006			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		6,522	0	6,522			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,635,306	0	1,635,306			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		4,595	0	4,595			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	184,517	-184,517	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	1,383,109	184,517	1,567,626	69,524.00	22.55	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2018 8:42 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		223,288	0	223,288	1,794.00	124.46	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,038,132	0	1,038,132	48,873.00	21.24	30.00
31.00	Laundry & Linen Service	8.00	22,635	0	22,635	2,112.00	10.72	31.00
32.00	Housekeeping	9.00	866,710	0	866,710	63,894.00	13.56	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	879,519	-627,886	251,633	16,850.00	14.93	34.00
35.00	Dietary under contract (see instructions)		323	0	323	4.00	80.75	35.00
36.00	Cafeteria	11.00	0	399,935	399,935	26,781.00	14.93	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	317,522	0	317,522	11,875.00	26.74	38.00
39.00	Central Services and Supply	14.00	412,485	0	412,485	24,434.00	16.88	39.00
40.00	Pharmacy	15.00	1,088,292	0	1,088,292	30,660.00	35.50	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2018 8:42 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		30,018,205	-317,086	29,701,119	1,187,959.00	25.00	1.00
2.00	Excluded area salaries (see instructions)		5,011,120	-473,512	4,537,608	206,742.00	21.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)		25,007,085	156,426	25,163,511	981,217.00	25.65	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,148,221	0	8,148,221	232,807.00	35.00	4.00
5.00	Subtotal wage-related costs (see inst.)		9,532,481	0	9,532,481	0.00	37.88	5.00
6.00	Total (sum of lines 3 thru 5)		42,687,787	156,426	42,844,213	1,214,024.00	35.29	6.00
7.00	Total overhead cost (see instructions)		6,416,532	-227,951	6,188,581	296,801.00	20.85	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2018 8:42 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,159,473	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	2,583,738	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,064,547	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	97,248	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	32,551	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	13,109	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	351,864	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,125,373	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	42,835	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	38,370	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,509,108	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/25/2018 8:42 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,444,728	9,509,108	1.00
2.00	Hospital	1,444,728	9,242,139	2.00
3.00	Subprovider - IPF	0	266,969	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-7 | Date/Time Prepared: 5/25/2018 8:42 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	17	0	17	4.00
5.00		RVX	21	0	21	5.00
6.00		RVL	11	0	11	6.00
7.00		RHX	1	0	1	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	575	0	575	12.00
13.00		RUB	1,336	0	1,336	13.00
14.00		RUA	1,123	0	1,123	14.00
15.00		RVC	88	0	88	15.00
16.00		RVB	242	0	242	16.00
17.00		RVA	125	0	125	17.00
18.00		RHC	48	0	48	18.00
19.00		RHB	19	0	19	19.00
20.00		RHA	6	0	6	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	15	0	15	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	15	0	15	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	4	0	4	50.00
51.00		CB2	8	0	8	51.00
52.00		CB1	10	0	10	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	2	0	2	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-7 | Date/Time Prepared: 5/25/2018 8:42 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	5	0	5	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	10	0	10	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	15	0	15	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	5	0	5	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,701	0	3,701	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	37900	37900	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	1,142,996	9.67		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	11,819,655			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/25/2018 8:42 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.156015	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,351,509	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	47,886,684	6.00
7.00	Medicaid cost (line 1 times line 6)	7,471,041	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	4,119,532	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,119,532	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,601,227	1,544,222	3,145,449	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	249,815	1,544,222	1,794,037	21.00
22.00	Payments received from patients for amounts previously written off as charity care	28,938	53,197	82,135	22.00
23.00	Cost of charity care (line 21 minus line 22)	220,877	1,491,025	1,711,902	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,578,166	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	356,017	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	547,718	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,030,448	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	976,526	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,688,428	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,807,960	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,487,333	1,487,333	904,963	2,392,296	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	62,040	62,040	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	184,517	29,276	213,793	-184,896	28,897	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,383,109	1,183,133	2,566,242	-733,053	1,833,189	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,434,978	1,434,978	0	1,434,978	6.00
7.00	00700	OPERATION OF PLANT	1,038,132	2,578,638	3,616,770	-13	3,616,757	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,635	29,118	51,753	-37	51,716	8.00
9.00	00900	HOUSEKEEPING	866,710	565,120	1,431,830	0	1,431,830	9.00
10.00	01000	DIETARY	879,519	852,349	1,731,868	-1,241,213	490,655	10.00
11.00	01100	CAFETERIA	0	0	0	787,516	787,516	11.00
13.00	01300	NURSING ADMINISTRATION	317,522	58,413	375,935	-48,457	327,478	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	412,485	736,433	1,148,918	-129,677	1,019,241	14.00
15.00	01500	PHARMACY	1,088,292	3,309,794	4,398,086	-3,058,351	1,339,735	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	-921	-921	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,724,026	2,268,190	7,992,216	-2,772,837	5,219,379	30.00
31.00	03100	INTENSIVE CARE UNIT	986,002	356,959	1,342,961	-127,541	1,215,420	31.00
40.00	04000	SUBPROVIDER - IPF	1,396,858	568,033	1,964,891	-23,762	1,941,129	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,354,595	1,068,496	2,423,091	-1,280,095	1,142,996	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,301,072	14,869,240	17,170,312	-12,126,811	5,043,501	50.00
51.00	05100	RECOVERY ROOM	1,552,649	479,067	2,031,716	-149,989	1,881,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	52,860	398,946	451,806	-225,166	226,640	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,675,568	1,182,801	2,858,369	-412,349	2,446,020	54.00
57.00	05700	CT SCAN	339,026	550,871	889,897	-76,614	813,283	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	420,573	600,380	1,020,953	-47,276	973,677	58.00
60.00	06000	LABORATORY	1,257,797	1,922,006	3,179,803	-557,180	2,622,623	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	460,467	460,467	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,207,037	1,207,037	64.00
65.00	06500	RESPIRATORY THERAPY	588,290	269,804	858,094	39,784	897,878	65.00
66.00	06600	PHYSICAL THERAPY	0	519,450	519,450	927,843	1,447,293	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	250,319	250,319	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	48,529	48,529	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	104,290	46,963	151,253	-19,081	132,172	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,124,035	6,124,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,820,828	9,820,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,230,508	3,230,508	73.00
74.00	07400	RENAL DIALYSIS	48,076	29,197	77,273	-14,492	62,781	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	50,189	50,189	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	125,395	279,186	404,581	-96,038	308,543	76.02
76.03	03140	CARDIOLOGY	717,951	1,070,014	1,787,965	-715,491	1,072,474	76.03
76.97	07697	CARDIAC REHABILITATION	403,844	142,618	546,462	-107,232	439,230	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	544,605	1,681,061	2,225,666	929,773	3,155,439	90.00
91.00	09100	EMERGENCY	1,781,138	1,529,128	3,310,266	-1,143,572	2,166,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	104	104	-104	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,567,536	42,097,099	69,664,635	-448,417	69,216,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	379,522	379,522	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	608,109	277,319	885,428	69,338	954,766	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	818,589	527,846	1,346,435	-443	1,345,992	194.09
194.10	07960	ARC INGALLS	832,969	442,904	1,275,873	0	1,275,873	194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	29,827,203	43,345,168	73,172,371	0	73,172,371	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-72,189	2,320,107		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	62,040		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,065,723	-1,036,826		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,115,099	12,948,288		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,434,978		6.00
7.00	00700	OPERATION OF PLANT	21,007	3,637,764		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-8,083	43,633		8.00
9.00	00900	HOUSEKEEPING	0	1,431,830		9.00
10.00	01000	DIETARY	0	490,655		10.00
11.00	01100	CAFETERIA	0	787,516		11.00
13.00	01300	NURSING ADMINISTRATION	1,654,634	1,982,112		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,019,241		14.00
15.00	01500	PHARMACY	0	1,339,735		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,188,850	1,187,929		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-194,240	5,025,139		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,215,420		31.00
40.00	04000	SUBPROVIDER - IPF	-144,865	1,796,264		40.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,142,996		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-146,250	4,897,251		50.00
51.00	05100	RECOVERY ROOM	0	1,881,727		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	226,640		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-57,206	2,388,814		54.00
57.00	05700	CT SCAN	0	813,283		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	973,677		58.00
60.00	06000	LABORATORY	-76,301	2,546,322		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	460,467		63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,207,037		64.00
65.00	06500	RESPIRATORY THERAPY	0	897,878		65.00
66.00	06600	PHYSICAL THERAPY	0	1,447,293		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	250,319		67.00
68.00	06800	SPEECH PATHOLOGY	0	48,529		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	132,172		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,124,035		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,820,828		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,230,508		73.00
74.00	07400	RENAL DIALYSIS	0	62,781		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	50,189		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	308,543		76.02
76.03	03140	CARDIOLOGY	-1,800	1,070,674		76.03
76.97	07697	CARDIAC REHABILITATION	-36,149	403,081		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,091	3,151,348		90.00
91.00	09100	EMERGENCY	-630,416	1,536,278		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,542,277	80,758,495		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0		194.00
194.01	07951	MEALS ON WHEELS	0	0		194.01
194.02	07952	MARKETING	0	0		194.02
194.03	07953	GUEST MEALS	0	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	379,522		194.04
194.05	07955	FOUNDATION	0	0		194.05
194.06	07956	DAYCARE CENTER	0	954,766		194.06
194.07	07957	UN-USED SQR FT - POB	0	0		194.07
194.08	07958	SENIOR SERVICES	0	0		194.08
194.09	07959	ARC BROMENN	0	1,345,992		194.09
194.10	07960	ARC INGALLS	0	1,275,873		194.10
200.00		TOTAL (SUM OF LINES 118 through 199)	11,542,277	84,714,648		200.00

RECLASSIFICATIONS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 8:42 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	399,935	387,581	1.00
2.00	PHYSICIAN/OTHER MEALS	194.04	192,738	186,784	2.00
3.00	DAYCARE CENTER	194.06	35,213	34,125	3.00
	0		627,886	608,490	
	F - DRUGS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,230,508	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	1,560	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	3,232,068	
	G - MED SUPPLIES RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,124,035	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	6,124,035	
	I - IMPLANTIBLE RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,820,828	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
	0		0	9,820,828	
	J - BLOOD RECLASS				
1.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	0	317,086	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		0	317,086		
	K - COST CENTER MAPPING					
1.00	ADULTS & PEDIATRICS	30.00	10,979	3,007		1.00
2.00	INTENSIVE CARE UNIT	31.00	2,262	838		2.00
3.00	OPERATING ROOM	50.00	236,639	88,200		3.00
4.00	ANESTHESIOLOGY	53.00	14,028	10,717		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	46,571	23,325		5.00
6.00	LABORATORY	60.00	4,035	858		6.00
7.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	70,706	72,675		7.00
8.00	INTRAVENOUS THERAPY	64.00	830,501	376,536		8.00
9.00	RESPIRATORY THERAPY	65.00	134,742	129,195		9.00
10.00	PHYSICAL THERAPY	66.00	613,964	460,487		10.00
11.00	OCCUPATIONAL THERAPY	67.00	87,498	162,821		11.00
12.00	SPEECH PATHOLOGY	68.00	0	48,529		12.00
13.00	PULMONARY FUNCTION TESTING	76.01	40,514	9,675		13.00
14.00	CARDIOLOGY	76.03	165,302	101,407		14.00
15.00	CLINIC	90.00	1,279,639	773,156		15.00
16.00	ADMINISTRATIVE & GENERAL	5.00	184,517	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0		3,721,897	2,261,426		
	M - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	904,963		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	62,040		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0		0	967,003		
500.00	Grand Total: Increases		4,349,783	23,330,936		500.00

RECLASSIFICATIONS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 8:42 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	627,886	608,490	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		627,886	608,490			
	F - DRUGS RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00		324	0		1.00
2.00	OPERATION OF PLANT	7.00	0	13	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	37	0		3.00
4.00	DIETARY	10.00	0	4,837	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,897	0		5.00
6.00	PHARMACY	15.00	0	3,018,636	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	18,283	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	70	0		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	2,505	0		9.00
10.00	OPERATING ROOM	50.00	0	46,638	0		10.00
11.00	RECOVERY ROOM	51.00	0	12,060	0		11.00
12.00	ANESTHESIOLOGY	53.00	0	16,046	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,487	0		13.00
14.00	CT SCAN	57.00	0	34,027	0		14.00
15.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	28,526	0		15.00
16.00	LABORATORY	60.00	0	100	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	3,863	0		17.00
18.00	RENAL DIALYSIS	74.00	0	61	0		18.00
19.00	GASTRO INTESTINAL SERVICES	76.02	0	939	0		19.00
20.00	CARDIOLOGY	76.03	0	2,455	0		20.00
21.00	CARDIAC REHABILITATION	76.97	0	54	0		21.00
22.00	CLINIC	90.00	0	20,148	0		22.00
23.00	EMERGENCY	91.00	0	8,619	0		23.00
24.00	ARC BROMENN	194.09	0	443	0		24.00
	0		0	3,232,068			
	G - MED SUPPLIES RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	104,604	0		1.00
2.00	PHARMACY	15.00	0	39,715	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	255,717	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	101,078	0		4.00
5.00	SUBPROVIDER - IPF	40.00	0	23,692	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	50,014	0		6.00
7.00	OPERATING ROOM	50.00	0	3,340,901	0		7.00
8.00	RECOVERY ROOM	51.00	0	137,674	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	233,684	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	245,434	0		10.00
11.00	CT SCAN	57.00	0	41,616	0		11.00
12.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	8,868	0		12.00
13.00	LABORATORY	60.00	0	126,940	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	125,453	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	884	0		15.00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,143	0		16.00
17.00	RENAL DIALYSIS	74.00	0	11,331	0		17.00
18.00	GASTRO INTESTINAL SERVICES	76.02	0	67,703	0		18.00
19.00	CARDIOLOGY	76.03	0	269,152	0		19.00
20.00	CARDIAC REHABILITATION	76.97	0	2,491	0		20.00
21.00	CLINIC	90.00	0	662,606	0		21.00
22.00	EMERGENCY	91.00	0	264,335	0		22.00
	0		0	6,124,035			
	I - IMPLANTIBLE RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	16,176	0		1.00
2.00	OPERATING ROOM	50.00	0	9,011,232	0		2.00
3.00	RECOVERY ROOM	51.00	0	255	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	181	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	39,585	0		5.00
6.00	CT SCAN	57.00	0	971	0		6.00
7.00	GASTRO INTESTINAL SERVICES	76.02	0	2,909	0		7.00
8.00	CARDIOLOGY	76.03	0	431,413	0		8.00
9.00	CLINIC	90.00	0	317,836	0		9.00
10.00	EMERGENCY	91.00	0	270	0		10.00
	0		0	9,820,828			
	J - BLOOD RECLASS						
1.00	OPERATING ROOM	50.00	644	0	0		1.00
2.00	LABORATORY	60.00	316,324	0	0		2.00
3.00	CARDIOLOGY	76.03	118	0	0		3.00
	0		317,086	0			

RECLASSIFICATIONS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/25/2018 8:42 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	K - COST CENTER MAPPING						
1.00	ADULTS & PEDIATRICS	30.00	1,672,665	840,158	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	24,834	6,289	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	701,463	526,113	0		3.00
4.00	OPERATING ROOM	50.00	25,728	26,507	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	156,485	36,254	0		5.00
6.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	4,401	5,481	0		6.00
7.00	LABORATORY	60.00	54,564	64,145	0		7.00
8.00	RESPIRATORY THERAPY	65.00	76,555	18,282	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	145,724	0		9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	6,606	2,332	0		10.00
11.00	RENAL DIALYSIS	74.00	2,262	838	0		11.00
12.00	GASTRO INTESTINAL SERVICES	76.02	9,220	15,267	0		12.00
13.00	CARDIOLOGY	76.03	182,661	96,401	0		13.00
14.00	CARDIAC REHABILITATION	76.97	77,727	26,960	0		14.00
15.00	CLINIC	90.00	35,583	86,849	0		15.00
16.00	EMERGENCY	91.00	506,626	363,722	0		16.00
17.00	HOME HEALTH AGENCY	101.00	0	104	0		17.00
18.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	184,517	0	0		18.00
	0		3,721,897	2,261,426			
	M - DEPRECIATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	379	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	917,246	9		2.00
3.00	NURSING ADMINISTRATION	13.00	0	48,457	0		3.00
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	921	0		4.00
	0		0	967,003			
500.00	Grand Total: Decreases		4,666,869	23,013,850			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2018 8:42 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,081,907	0	0	0	0	1.00
2.00	Land Improvements	6,382,159	51,304	0	51,304	0	2.00
3.00	Buildings and Fixtures	61,678,006	6,194,828	0	6,194,828	7,939	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	19,967,949	244,146	0	244,146	0	5.00
6.00	Movable Equipment	57,958,447	3,268,128	0	3,268,128	806,063	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	152,068,468	9,758,406	0	9,758,406	814,002	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	152,068,468	9,758,406	0	9,758,406	814,002	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	6,081,907	0	1.00
2.00	Land Improvements	6,433,463	0	2.00
3.00	Buildings and Fixtures	67,864,895	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	20,212,095	0	5.00
6.00	Movable Equipment	60,420,512	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	161,012,872	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	161,012,872	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2018 8:42 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	1,487,333	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,487,333	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,487,333	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,487,333	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2018 8:42 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	100,592,361	0	100,592,361	0.624747	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	60,420,512	0	60,420,512	0.375253	0	2.00
3.00	Total (sum of lines 1-2)	161,012,873	0	161,012,873	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: 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	2,392,296	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	62,040	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,454,336	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	-72,189	0	0	0	2,320,107	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	62,040	2.00
3.00	Total (sum of lines 1-2)	-72,189	0	0	0	2,382,147	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 8:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-2	CAP REL COSTS-BLDG & FIXT	1.00	11	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)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,303,836			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	14,869,404			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/25/2018 8:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	PHARMACY - MISC REVENUE	B	0	PHARMACY	15.00	0	33.01
33.03	PLANT OP OTHER REV	B	-82,323	OPERATION OF PLANT	7.00	0	33.03
33.04	LAUNDRY REVENUE	B	-8,083	LAUNDRY & LINEN SERVICE	8.00	0	33.04
33.08	MISC INCOME -A&P	B	-58,350	ADULTS & PEDIATRICS	30.00	0	33.08
33.09	MISC INCOME - LABORATORY	B	-850	LABORATORY	60.00	0	33.09
33.10	RADIOLOGY - MISC REVENUE	B	-1,078	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.12	CARDIAC REHAB - MISC REV	B	-26,817	CARDIAC REHABILITATION	76.97	0	33.12
33.13	COUNSELING CTR MISC REV	B	0	CLINIC	90.00	0	33.13
33.14	EMERGENCY ROOM - MISC REVENUE	B	-50,907	EMERGENCY	91.00	0	33.14
33.16	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.16
33.17	INTEREST PROPERTY TAXES	A	0	CAP REL COSTS-BLDG & FIXT	1.00	13	33.17
33.18	ADVERTISING A&P	A	-80,028	ADULTS & PEDIATRICS	30.00	0	33.18
33.19	ADVERTISING ER	A	0	EMERGENCY	91.00	0	33.19
33.20	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.20
33.21	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.21
33.31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33.32	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.32
33.37	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.37
33.39	INTEREST EXPENSE	A	-171,351	CAP REL COSTS-BLDG & FIXT	1.00	11	33.39
33.40	POB SECURITY COST	A	-22,058	OPERATION OF PLANT	7.00	0	33.40
33.41	POB SECURITY COST	A	-5,515	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.41
33.42	GRANT EXPENSES	A	0	ADULTS & PEDIATRICS	30.00	0	33.42
33.43	GRANT EXPENSES	A	0	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	33.43
33.44	SELF FUNDED INSURANCE	A	-1,515,929	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.44
33.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.45
33.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.46
33.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.47
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		11,542,277				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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2018 8:42 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	455,721	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE ALLOCATION	1,188,850	0	2.00
3.00	13.00	NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	1,654,634	0	3.00
3.01	7.00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	125,388	0	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	11,115,099	0	4.00
4.01	30.00	ADULTS & PEDIATRICS	HOME OFFICE ALLOCATION	230,548	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	943,764	844,600	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			15,714,004	844,600	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		100.00	UNITY POINT	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

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.

(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: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/25/2018 8:42 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	455,721	0		1.00
2.00	1,188,850	0		2.00
3.00	1,654,634	0		3.00
3.01	125,388	0		3.01
4.00	11,115,099	0		4.00
4.01	230,548	0		4.01
4.02	99,164	11		4.02
5.00	14,869,404			5.00

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

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

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

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

6.00	HEALTH SYSTEM		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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2018 8:42 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	AGGREGATE-ADULTS & PEDIATRICS	289,285	286,410	2,875	211,500	31	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	144,865	144,865	0	181,300	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	150,750	146,250	4,500	246,400	52	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	6,500	0	6,500	239,400	132	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	57,256	56,128	1,128	271,900	35	5.00
6.00	60.00	AGGREGATE-LABORATORY	75,576	75,451	125	260,300	6	6.00
7.00	76.03	AGGREGATE-CARDIOLOGY	1,800	1,800	0	211,500	0	7.00
8.00	76.97	AGGREGATE-CARDIAC REHABILITATION	9,332	9,332	0	211,500	0	8.00
9.00	90.00	AGGREGATE-CLINIC	6,941	4,091	2,850	211,500	96	9.00
10.00	91.00	AGGREGATE-EMERGENCY	582,051	579,051	3,000	211,500	25	10.00
200.00			1,324,356	1,303,378	20,978		377	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	AGGREGATE-ADULTS & PEDIATRICS	3,152	158	0	0	0	1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	0	0	2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	6,160	308	0	0	0	3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	15,193	760	0	0	0	4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	4,575	229	0	0	0	5.00
6.00	60.00	AGGREGATE-LABORATORY	751	38	0	0	0	6.00
7.00	76.03	AGGREGATE-CARDIOLOGY	0	0	0	0	0	7.00
8.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	0	0	0	0	8.00
9.00	90.00	AGGREGATE-CLINIC	9,762	488	0	0	0	9.00
10.00	91.00	AGGREGATE-EMERGENCY	2,542	127	0	0	0	10.00
200.00			42,135	2,108	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	AGGREGATE-ADULTS & PEDIATRICS	0	3,152	0	286,410		1.00
2.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	0	0	144,865		2.00
3.00	50.00	AGGREGATE-OPERATING ROOM	0	6,160	0	146,250		3.00
4.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	15,193	0	0		4.00
5.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	4,575	0	56,128		5.00
6.00	60.00	AGGREGATE-LABORATORY	0	751	0	75,451		6.00
7.00	76.03	AGGREGATE-CARDIOLOGY	0	0	0	1,800		7.00
8.00	76.97	AGGREGATE-CARDIAC REHABILITATION	0	0	0	9,332		8.00
9.00	90.00	AGGREGATE-CLINIC	0	9,762	0	4,091		9.00
10.00	91.00	AGGREGATE-EMERGENCY	0	2,542	458	579,509		10.00
200.00			0	42,135	458	1,303,836		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 8:42 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,320,107	2,320,107				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	62,040		62,040			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,036,826	78,128	2,089	-956,609		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,948,288	288,194	7,706	0	13,244,188	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,434,978	367,082	9,818	0	1,811,878	6.00
7.00	00700	OPERATION OF PLANT	3,637,764	26,134	699	0	3,664,597	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	43,633	21,176	566	0	65,375	8.00
9.00	00900	HOUSEKEEPING	1,431,830	35,880	959	0	1,468,669	9.00
10.00	01000	DIETARY	490,655	30,080	804	0	521,539	10.00
11.00	01100	CAFETERIA	787,516	79,834	2,135	0	869,485	11.00
13.00	01300	NURSING ADMINISTRATION	1,982,112	10,896	291	0	1,993,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,019,241	0	0	0	1,019,241	14.00
15.00	01500	PHARMACY	1,339,735	18,138	485	0	1,358,358	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,187,929	0	0	0	1,187,929	16.00
17.00	01700	SOCIAL SERVICE	0	787	21	0	808	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,025,139	361,077	9,655	0	5,395,871	30.00
31.00	03100	INTENSIVE CARE UNIT	1,215,420	50,073	1,339	0	1,266,832	31.00
40.00	04000	SUBPROVIDER - IPF	1,796,264	38,390	1,027	0	1,835,681	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,142,996	90,945	2,432	0	1,236,373	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,897,251	232,574	6,219	0	5,136,044	50.00
51.00	05100	RECOVERY ROOM	1,881,727	0	0	0	1,881,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	226,640	3,814	102	0	230,556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,388,814	150,808	4,033	0	2,543,655	54.00
57.00	05700	CT SCAN	813,283	0	0	0	813,283	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	973,677	0	0	0	973,677	58.00
60.00	06000	LABORATORY	2,546,322	64,095	1,714	0	2,612,131	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	460,467	0	0	0	460,467	63.00
64.00	06400	INTRAVENOUS THERAPY	1,207,037	0	0	0	1,207,037	64.00
65.00	06500	RESPIRATORY THERAPY	897,878	23,372	625	0	921,875	65.00
66.00	06600	PHYSICAL THERAPY	1,447,293	19,388	518	0	1,467,199	66.00
67.00	06700	OCCUPATIONAL THERAPY	250,319	0	0	0	250,319	67.00
68.00	06800	SPEECH PATHOLOGY	48,529	0	0	0	48,529	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	132,172	48,395	1,294	0	181,861	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,124,035	62,059	1,659	0	6,187,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,820,828	0	0	0	9,820,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,230,508	0	0	0	3,230,508	73.00
74.00	07400	RENAL DIALYSIS	62,781	8,667	232	0	71,680	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	50,189	0	0	0	50,189	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	308,543	0	0	0	308,543	76.02
76.03	03140	CARDIOLOGY	1,070,674	0	0	0	1,070,674	76.03
76.97	07697	CARDIAC REHABILITATION	403,081	0	0	0	403,081	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,151,348	53,023	1,418	0	3,205,789	90.00
91.00	09100	EMERGENCY	1,536,278	63,374	1,695	0	1,601,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	80,758,495	2,226,383	59,535	0	81,618,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,951	667	0	25,618	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	379,522	0	0	0	379,522	194.04
194.05	07955	FOUNDATION	0	15,563	416	0	15,979	194.05
194.06	07956	DAYCARE CENTER	954,766	50,387	1,347	0	1,006,500	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,823	75	0	2,898	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	1,345,992	0	0	0	1,345,992	194.09
194.10	07960	ARC INGALLS	1,275,873	0	0	0	1,275,873	194.10
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 8:42 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	
201.00	Negative Cost Centers		0	0	-956,609	-956,609	201.00
202.00	TOTAL (sum lines 118 through 201)	84,714,648	2,320,107	62,040	-956,609	84,714,648	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,244,188					5.00
6.00	00600	MAINTENANCE & REPAIRS	331,324	2,143,202				6.00
7.00	00700	OPERATION OF PLANT	670,116	35,300	4,370,013			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,955	28,603	59,299	165,232		8.00
9.00	00900	HOUSEKEEPING	268,564	48,465	100,475	0	1,886,173	9.00
10.00	01000	DIETARY	95,370	40,630	84,233	0	37,736	10.00
11.00	01100	CAFETERIA	158,996	107,834	223,557	0	100,153	11.00
13.00	01300	NURSING ADMINISTRATION	364,499	14,718	30,512	0	13,669	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	186,380	0	0	0	0	14.00
15.00	01500	PHARMACY	248,392	24,500	50,792	0	22,755	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	217,227	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	148	1,063	2,204	0	987	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	986,700	487,718	1,011,115	79,954	452,974	30.00
31.00	03100	INTENSIVE CARE UNIT	231,655	67,635	140,218	10,416	62,817	31.00
40.00	04000	SUBPROVIDER - IPF	335,676	51,854	107,502	28,051	48,161	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	226,086	122,842	254,670	46,811	114,091	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	939,187	314,143	651,269	0	291,766	50.00
51.00	05100	RECOVERY ROOM	344,096	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,160	5,151	10,679	0	4,784	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	465,138	203,700	422,303	0	189,190	54.00
57.00	05700	CT SCAN	148,719	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	178,049	0	0	0	0	58.00
60.00	06000	LABORATORY	477,659	86,575	179,483	0	80,408	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	84,202	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	220,721	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	168,576	31,569	65,447	0	29,320	65.00
66.00	06600	PHYSICAL THERAPY	268,295	26,187	54,290	0	24,322	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,774	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	8,874	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,255	65,368	135,518	0	60,712	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,131,505	83,825	173,782	0	77,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,795,881	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	590,737	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	13,108	11,707	24,271	0	10,873	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	9,178	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	56,421	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	195,786	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	73,708	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	586,217	71,619	148,478	0	66,518	90.00
91.00	09100	EMERGENCY	292,826	85,601	177,465	0	79,504	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,503,160	2,016,607	4,107,562	165,232	1,768,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,685	33,702	69,870	0	31,302	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	69,400	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,922	21,021	43,580	0	19,524	194.05
194.06	07956	DAYCARE CENTER	184,051	68,059	141,096	0	63,211	194.06
194.07	07957	UN-USED SQR FT - POB	530	3,813	7,905	0	3,542	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	246,131	0	0	0	0	194.09
194.10	07960	ARC INGALLS	233,309	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	13,244,188	2,143,202	4,370,013	165,232	1,886,173	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	779,508					10.00
11.00	01100	CAFETERIA	0	1,460,025				11.00
13.00	01300	NURSING ADMINISTRATION	0	23,026	2,439,723			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,913	0	1,235,534		14.00
15.00	01500	PHARMACY	0	78,921	0	0	1,783,718	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	377,197	294,588	669,539	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	49,141	69,866	158,790	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	132,333	101,297	230,226	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	220,837	47,364	107,647	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	182,164	414,018	0	0	50.00
51.00	05100	RECOVERY ROOM	0	112,595	255,903	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,851	11,024	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	113,538	258,046	0	0	54.00
57.00	05700	CT SCAN	0	24,585	55,877	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	30,180	68,592	0	0	58.00
60.00	06000	LABORATORY	0	87,549	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	5,127	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	60,226	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	46,881	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	44,523	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,084	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	474,640	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	760,894	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,783,718	73.00
74.00	07400	RENAL DIALYSIS	0	3,322	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	92,425	210,061	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	779,508	1,460,025	2,439,723	1,235,534	1,783,718	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	779,508	1,460,025	2,439,723	1,235,534	1,783,718	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,405,156					16.00
17.00	01700	SOCIAL SERVICE	0	5,210				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	86,873	2,522	9,845,051	0	9,845,051	30.00
31.00	03100	INTENSIVE CARE UNIT	18,075	328	2,075,773	0	2,075,773	31.00
40.00	04000	SUBPROVIDER - IPF	23,568	884	2,895,233	0	2,895,233	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,230	1,476	2,393,427	0	2,393,427	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	284,109	0	8,212,700	0	8,212,700	50.00
51.00	05100	RECOVERY ROOM	65,023	0	2,659,344	0	2,659,344	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	83,970	0	393,175	0	393,175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,734	0	4,256,304	0	4,256,304	54.00
57.00	05700	CT SCAN	83,631	0	1,126,095	0	1,126,095	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	52,309	0	1,302,807	0	1,302,807	58.00
60.00	06000	LABORATORY	85,528	0	3,609,333	0	3,609,333	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	4,864	0	554,660	0	554,660	63.00
64.00	06400	INTRAVENOUS THERAPY	31,887	0	1,519,871	0	1,519,871	64.00
65.00	06500	RESPIRATORY THERAPY	28,415	0	1,292,083	0	1,292,083	65.00
66.00	06600	PHYSICAL THERAPY	19,967	0	1,904,783	0	1,904,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,828	0	300,921	0	300,921	67.00
68.00	06800	SPEECH PATHOLOGY	1,230	0	58,633	0	58,633	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,459	0	486,257	0	486,257	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	95,738	0	8,225,097	0	8,225,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	85,291	0	12,462,894	0	12,462,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	88,079	0	5,693,042	0	5,693,042	73.00
74.00	07400	RENAL DIALYSIS	69	0	135,030	0	135,030	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,995	0	62,362	0	62,362	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	14,430	0	379,394	0	379,394	76.02
76.03	03140	CARDIOLOGY	49,844	0	1,316,304	0	1,316,304	76.03
76.97	07697	CARDIAC REHABILITATION	3,813	0	480,602	0	480,602	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	48,304	0	4,126,925	0	4,126,925	90.00
91.00	09100	EMERGENCY	63,893	0	2,603,122	0	2,603,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,405,156	5,210	80,371,222	0	80,371,222	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	165,177	0	165,177	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	448,922	0	448,922	194.04
194.05	07955	FOUNDATION	0	0	103,026	0	103,026	194.05
194.06	07956	DAYCARE CENTER	0	0	1,462,917	0	1,462,917	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	18,688	0	18,688	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	1,592,123	0	1,592,123	194.09
194.10	07960	ARC INGALLS	0	0	1,509,182	0	1,509,182	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	-956,609	0	-956,609	201.00
202.00		TOTAL (sum lines 118 through 201)	1,405,156	5,210	84,714,648	0	84,714,648	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,171	78,128	2,089	86,388	86,388	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,722	288,194	7,706	321,622	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	187,752	367,082	9,818	564,652	0	6.00
7.00	00700	OPERATION OF PLANT	90,276	26,134	699	117,109	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,176	566	21,742	0	8.00
9.00	00900	HOUSEKEEPING	11,368	35,880	959	48,207	0	9.00
10.00	01000	DIETARY	37,215	30,080	804	68,099	0	10.00
11.00	01100	CAFETERIA	0	79,834	2,135	81,969	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,896	291	11,187	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	270,982	0	0	270,982	0	14.00
15.00	01500	PHARMACY	52,520	18,138	485	71,143	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	787	21	808	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,756	361,077	9,655	487,488	0	30.00
31.00	03100	INTENSIVE CARE UNIT	64,259	50,073	1,339	115,671	0	31.00
40.00	04000	SUBPROVIDER - IPF	82,341	38,390	1,027	121,758	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	18,534	90,945	2,432	111,911	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	909,204	232,574	6,219	1,147,997	0	50.00
51.00	05100	RECOVERY ROOM	11,039	0	0	11,039	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	129,105	3,814	102	133,021	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	248,332	150,808	4,033	403,173	0	54.00
57.00	05700	CT SCAN	356,326	0	0	356,326	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	321,644	0	0	321,644	0	58.00
60.00	06000	LABORATORY	136,927	64,095	1,714	202,736	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	9,852	0	0	9,852	0	63.00
64.00	06400	INTRAVENOUS THERAPY	44,957	0	0	44,957	0	64.00
65.00	06500	RESPIRATORY THERAPY	31,731	23,372	625	55,728	0	65.00
66.00	06600	PHYSICAL THERAPY	19,036	19,388	518	38,942	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,032	0	0	3,032	0	67.00
68.00	06800	SPEECH PATHOLOGY	272	0	0	272	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,413	48,395	1,294	59,102	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	62,059	1,659	63,718	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,467	8,667	232	11,366	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	1,926	0	0	1,926	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	165,540	0	0	165,540	0	76.02
76.03	03140	CARDIOLOGY	113,223	0	0	113,223	0	76.03
76.97	07697	CARDIAC REHABILITATION	23,036	0	0	23,036	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	121,623	53,023	1,418	176,064	0	90.00
91.00	09100	EMERGENCY	99,059	63,374	1,695	164,128	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,721,640	2,226,383	59,535	6,007,558	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,951	667	25,618	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	15,563	416	15,979	0	194.05
194.06	07956	DAYCARE CENTER	1,786	50,387	1,347	53,520	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	2,823	75	2,898	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	86,388	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 8:42 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	
202.00	TOTAL (sum lines 118 through 201)	3,723,426	2,320,107	62,040	6,105,573	86,388	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	321,622					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,047	572,699				6.00
7.00	00700	OPERATION OF PLANT	16,274	9,433	142,816			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	290	7,643	1,938	31,613		8.00
9.00	00900	HOUSEKEEPING	6,522	12,951	3,284	0	70,964	9.00
10.00	01000	DIETARY	2,316	10,857	2,753	0	1,420	10.00
11.00	01100	CAFETERIA	3,861	28,815	7,306	0	3,768	11.00
13.00	01300	NURSING ADMINISTRATION	8,852	3,933	997	0	514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,526	0	0	0	0	14.00
15.00	01500	PHARMACY	6,032	6,547	1,660	0	856	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,276	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	4	284	72	0	37	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,963	130,328	33,046	15,297	17,044	30.00
31.00	03100	INTENSIVE CARE UNIT	5,626	18,073	4,582	1,993	2,363	31.00
40.00	04000	SUBPROVIDER - IPF	8,152	13,856	3,513	5,367	1,812	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,491	32,825	8,323	8,956	4,292	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,809	83,944	21,284	0	10,977	50.00
51.00	05100	RECOVERY ROOM	8,357	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,024	1,376	349	0	180	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,296	54,432	13,801	0	7,118	54.00
57.00	05700	CT SCAN	3,612	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	4,324	0	0	0	0	58.00
60.00	06000	LABORATORY	11,600	23,134	5,866	0	3,025	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	2,045	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	5,360	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,094	8,436	2,139	0	1,103	65.00
66.00	06600	PHYSICAL THERAPY	6,516	6,998	1,774	0	915	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,112	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	216	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	808	17,467	4,429	0	2,284	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,480	22,399	5,679	0	2,929	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,588	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,347	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	318	3,128	793	0	409	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	223	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,370	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	4,755	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	1,790	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	14,237	19,138	4,852	0	2,503	90.00
91.00	09100	EMERGENCY	7,112	22,874	5,800	0	2,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	303,625	538,871	134,240	31,613	66,540	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	114	9,006	2,283	0	1,178	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	1,685	0	0	0	0	194.04
194.05	07955	FOUNDATION	71	5,617	1,424	0	735	194.05
194.06	07956	DAYCARE CENTER	4,470	18,186	4,611	0	2,378	194.06
194.07	07957	UN-USED SQR FT - POB	13	1,019	258	0	133	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	5,978	0	0	0	0	194.09
194.10	07960	ARC INGALLS	5,666	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	321,622	572,699	142,816	31,613	70,964	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	85,445					10.00
11.00	01100	CAFETERIA	0	125,719				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,983	27,466			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,576	0	278,084		14.00
15.00	01500	PHARMACY	0	6,795	0	0	93,033	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	41,345	25,369	7,543	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,387	6,016	1,787	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	14,506	8,722	2,591	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	24,207	4,078	1,212	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	15,685	4,660	0	0	50.00
51.00	05100	RECOVERY ROOM	0	9,695	2,880	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	418	124	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,776	2,904	0	0	54.00
57.00	05700	CT SCAN	0	2,117	629	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,599	772	0	0	58.00
60.00	06000	LABORATORY	0	7,538	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	441	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,186	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,037	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,834	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	610	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	106,829	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	171,255	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	93,033	73.00
74.00	07400	RENAL DIALYSIS	0	286	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	7,958	2,364	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,445	125,719	27,466	278,084	93,033	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,445	125,719	27,466	278,084	93,033	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,276					16.00
17.00	01700	SOCIAL SERVICE	0	1,205				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	318	583	782,324	0	782,324	30.00
31.00	03100	INTENSIVE CARE UNIT	66	76	161,640	0	161,640	31.00
40.00	04000	SUBPROVIDER - IPF	86	205	180,568	0	180,568	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	56	341	201,692	0	201,692	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,165	0	1,308,521	0	1,308,521	50.00
51.00	05100	RECOVERY ROOM	238	0	32,209	0	32,209	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	308	0	136,800	0	136,800	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223	0	502,723	0	502,723	54.00
57.00	05700	CT SCAN	307	0	362,991	0	362,991	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	192	0	329,531	0	329,531	58.00
60.00	06000	LABORATORY	314	0	254,213	0	254,213	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	18	0	12,356	0	12,356	63.00
64.00	06400	INTRAVENOUS THERAPY	117	0	55,620	0	55,620	64.00
65.00	06500	RESPIRATORY THERAPY	104	0	75,641	0	75,641	65.00
66.00	06600	PHYSICAL THERAPY	73	0	59,052	0	59,052	66.00
67.00	06700	OCCUPATIONAL THERAPY	18	0	4,162	0	4,162	67.00
68.00	06800	SPEECH PATHOLOGY	5	0	493	0	493	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9	0	84,709	0	84,709	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	351	0	229,385	0	229,385	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	313	0	215,156	0	215,156	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	323	0	107,703	0	107,703	73.00
74.00	07400	RENAL DIALYSIS	0	0	16,300	0	16,300	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	11	0	2,160	0	2,160	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	53	0	166,963	0	166,963	76.02
76.03	03140	CARDIOLOGY	183	0	118,161	0	118,161	76.03
76.97	07697	CARDIAC REHABILITATION	14	0	24,840	0	24,840	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	177	0	216,971	0	216,971	90.00
91.00	09100	EMERGENCY	234	0	213,461	0	213,461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,276	1,205	5,856,345	0	5,856,345	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	38,199	0	38,199	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	1,685	0	1,685	194.04
194.05	07955	FOUNDATION	0	0	23,826	0	23,826	194.05
194.06	07956	DAYCARE CENTER	0	0	83,165	0	83,165	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	4,321	0	4,321	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	5,978	0	5,978	194.09
194.10	07960	ARC INGALLS	0	0	5,666	0	5,666	194.10
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	86,388	0	86,388	201.00
202.00		TOTAL (sum lines 118 through 201)	5,276	1,205	6,105,573	0	6,105,573	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	421,597					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		421,597				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,197	14,197	29,642,686			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,369	52,369	1,383,109	-13,244,188	72,427,069	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,704	66,704	0	0	1,811,878	6.00
7.00	00700	OPERATION OF PLANT	4,749	4,749	1,038,132	0	3,664,597	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	22,635	0	65,375	8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	866,710	0	1,468,669	9.00
10.00	01000	DIETARY	5,466	5,466	251,630	0	521,539	10.00
11.00	01100	CAFETERIA	14,507	14,507	399,938	0	869,485	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	317,522	0	1,993,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	412,485	0	1,019,241	14.00
15.00	01500	PHARMACY	3,296	3,296	1,088,292	0	1,358,358	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,187,929	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	0	808	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	4,062,338	0	5,395,871	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	963,430	0	1,266,832	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	1,396,858	0	1,835,681	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,526	16,526	653,132	0	1,236,373	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	2,511,984	0	5,136,044	50.00
51.00	05100	RECOVERY ROOM	0	0	1,552,649	0	1,881,727	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	66,888	0	230,556	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	1,565,654	0	2,543,655	54.00
57.00	05700	CT SCAN	0	0	339,026	0	813,283	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	416,172	0	973,677	58.00
60.00	06000	LABORATORY	11,647	11,647	1,207,268	0	2,612,131	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	70,706	0	460,467	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	830,501	0	1,207,037	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	646,477	0	921,875	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	613,964	0	1,467,199	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	87,498	0	250,319	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	48,529	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	97,684	0	181,861	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	0	6,187,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,820,828	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,230,508	73.00
74.00	07400	RENAL DIALYSIS	1,575	1,575	45,814	0	71,680	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	40,514	0	50,189	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	116,175	0	308,543	76.02
76.03	03140	CARDIOLOGY	0	0	700,592	0	1,070,674	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	326,117	0	403,081	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	1,788,662	0	3,205,789	90.00
91.00	09100	EMERGENCY	11,516	11,516	1,274,512	0	1,601,347	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	404,566	404,566	27,155,068	-13,244,188	68,374,687	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	0	25,618	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	192,738	0	379,522	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	0	15,979	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	643,322	0	1,006,500	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	0	2,898	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	818,589	0	1,345,992	194.09
194.10	07960	ARC INGALLS	0	0	832,969	0	1,275,873	194.10
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,320,107	62,040	-956,609		13,244,188	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.503139	0.147155	0.000000		0.182862	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			86,388		321,622	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002914		0.004441	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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	288,327					6.00
7.00	00700	OPERATION OF PLANT	4,749	283,578				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,848	3,848	22,160			8.00
9.00	00900	HOUSEKEEPING	6,520	6,520	0	273,210		9.00
10.00	01000	DIETARY	5,466	5,466	0	5,466	22,160	10.00
11.00	01100	CAFETERIA	14,507	14,507	0	14,507	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,980	1,980	0	1,980	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,296	3,296	0	3,296	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,613	65,613	10,723	65,613	10,723	30.00
31.00	03100	INTENSIVE CARE UNIT	9,099	9,099	1,397	9,099	1,397	31.00
40.00	04000	SUBPROVIDER - IPF	6,976	6,976	3,762	6,976	3,762	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,526	16,526	6,278	16,526	6,278	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	42,262	42,262	0	42,262	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	693	693	0	693	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,404	27,404	0	27,404	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	11,647	11,647	0	11,647	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	4,247	4,247	0	4,247	0	65.00
66.00	06600	PHYSICAL THERAPY	3,523	3,523	0	3,523	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,794	8,794	0	8,794	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,277	11,277	0	11,277	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,575	1,575	0	1,575	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,635	9,635	0	9,635	0	90.00
91.00	09100	EMERGENCY	11,516	11,516	0	11,516	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	271,296	266,547	22,160	256,179	22,160	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,534	4,534	0	4,534	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	2,828	2,828	0	2,828	0	194.05
194.06	07956	DAYCARE CENTER	9,156	9,156	0	9,156	0	194.06
194.07	07957	UN-USED SQR FT - POB	513	513	0	513	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
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)	2,143,202	4,370,013	165,232	1,886,173	779,508	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	7.433234	15.410268	7.456318	6.903748	35.176354	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	572,699	142,816	31,613	70,964	85,445	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.986283	0.503622	1.426579	0.259742	3.855821	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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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
11.00	01100	CAFETERIA	20,133,356					11.00
13.00	01300	NURSING ADMINISTRATION	317,522	14,802,643				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	412,485	0	15,947,033			14.00
15.00	01500	PHARMACY	1,088,292	0	0	3,230,506		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	515,149,757	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,062,338	4,062,338	0	0	31,844,815	30.00
31.00	03100	INTENSIVE CARE UNIT	963,430	963,430	0	0	6,625,842	31.00
40.00	04000	SUBPROVIDER - IPF	1,396,858	1,396,858	0	0	8,639,317	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	653,132	653,132	0	0	5,582,978	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,511,984	2,511,984	0	0	104,208,526	50.00
51.00	05100	RECOVERY ROOM	1,552,649	1,552,649	0	0	23,835,400	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	66,888	66,888	0	0	30,780,703	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,565,654	1,565,654	0	0	22,263,042	54.00
57.00	05700	CT SCAN	339,026	339,026	0	0	30,656,546	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	416,172	416,172	0	0	19,174,689	58.00
60.00	06000	LABORATORY	1,207,268	0	0	0	31,352,086	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	70,706	0	0	0	1,783,130	63.00
64.00	06400	INTRAVENOUS THERAPY	830,501	0	0	0	11,688,811	64.00
65.00	06500	RESPIRATORY THERAPY	646,477	0	0	0	10,416,123	65.00
66.00	06600	PHYSICAL THERAPY	613,964	0	0	0	7,319,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	1,769,672	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	451,036	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,684	0	0	0	901,253	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,126,205	0	35,094,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,820,828	0	31,264,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,230,506	32,286,843	73.00
74.00	07400	RENAL DIALYSIS	45,814	0	0	0	25,286	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	1,097,834	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	5,289,527	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	18,271,440	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	1,397,780	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	17,706,918	90.00
91.00	09100	EMERGENCY	1,274,512	1,274,512	0	0	23,421,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,133,356	14,802,643	15,947,033	3,230,506	515,149,757	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0	0	0	0	0	194.00
194.01	07951	MEALS ON WHEELS	0	0	0	0	0	194.01
194.02	07952	MARKETING	0	0	0	0	0	194.02
194.03	07953	GUEST MEALS	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0	0	0	0	0	194.04
194.05	07955	FOUNDATION	0	0	0	0	0	194.05
194.06	07956	DAYCARE CENTER	0	0	0	0	0	194.06
194.07	07957	UN-USED SQR FT - POB	0	0	0	0	0	194.07
194.08	07958	SENIOR SERVICES	0	0	0	0	0	194.08
194.09	07959	ARC BROMENN	0	0	0	0	0	194.09
194.10	07960	ARC INGALLS	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	CAFETERIA (GROSS SALARIE)	NURSING ADMINISTRATION (NURSING SALARIE)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	1,460,025	2,439,723	1,235,534	1,783,718	1,405,156	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.072518	0.164817	0.077477	0.552148	0.002728	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	125,719	27,466	278,084	93,033	5,276	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006244	0.001855	0.017438	0.028798	0.000010	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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)		
			17.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
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
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE	22,160		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	10,723		30.00
31.00	03100	INTENSIVE CARE UNIT	1,397		31.00
40.00	04000	SUBPROVIDER - IPF	3,762		40.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	6,278		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		54.00
57.00	05700	CT SCAN	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
60.00	06000	LABORATORY	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	0		65.00
66.00	06600	PHYSICAL THERAPY	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		73.00
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03950	ANCILLARY	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0		76.02
76.03	03140	CARDIOLOGY	0		76.03
76.97	07697	CARDIAC REHABILITATION	0		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,160		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190.00
194.00	07950	UN-USED SQR FT - HOSPITAL	0		194.00
194.01	07951	MEALS ON WHEELS	0		194.01
194.02	07952	MARKETING	0		194.02
194.03	07953	GUEST MEALS	0		194.03
194.04	07954	PHYSICIAN/OTHER MEALS	0		194.04
194.05	07955	FOUNDATION	0		194.05
194.06	07956	DAYCARE CENTER	0		194.06
194.07	07957	UN-USED SQR FT - POB	0		194.07
194.08	07958	SENIOR SERVICES	0		194.08
194.09	07959	ARC BROMENN	0		194.09
194.10	07960	ARC INGALLS	0		194.10
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)	5,210		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/25/2018 8:42 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)										
			17.00										
203.00		Unit cost multiplier (Wkst. B, Part I)	0.235108										203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,205										204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.054377										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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 8:42 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,845,051		9,845,051	0	9,845,051	30.00
31.00	03100	INTENSIVE CARE UNIT	2,075,773		2,075,773	0	2,075,773	31.00
40.00	04000	SUBPROVIDER - IPF	2,895,233		2,895,233	0	2,895,233	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,393,427		2,393,427	0	2,393,427	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,212,700		8,212,700	0	8,212,700	50.00
51.00	05100	RECOVERY ROOM	2,659,344		2,659,344	0	2,659,344	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	393,175		393,175	0	393,175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,256,304		4,256,304	0	4,256,304	54.00
57.00	05700	CT SCAN	1,126,095		1,126,095	0	1,126,095	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,302,807		1,302,807	0	1,302,807	58.00
60.00	06000	LABORATORY	3,609,333		3,609,333	0	3,609,333	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	554,660		554,660	0	554,660	63.00
64.00	06400	INTRAVENOUS THERAPY	1,519,871		1,519,871	0	1,519,871	64.00
65.00	06500	RESPIRATORY THERAPY	1,292,083	0	1,292,083	0	1,292,083	65.00
66.00	06600	PHYSICAL THERAPY	1,904,783	0	1,904,783	0	1,904,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,921	0	300,921	0	300,921	67.00
68.00	06800	SPEECH PATHOLOGY	58,633	0	58,633	0	58,633	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486,257		486,257	0	486,257	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,225,097		8,225,097	0	8,225,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,462,894		12,462,894	0	12,462,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,693,042		5,693,042	0	5,693,042	73.00
74.00	07400	RENAL DIALYSIS	135,030		135,030	0	135,030	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,362		62,362	0	62,362	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	379,394		379,394	0	379,394	76.02
76.03	03140	CARDIOLOGY	1,316,304		1,316,304	0	1,316,304	76.03
76.97	07697	CARDIAC REHABILITATION	480,602		480,602	0	480,602	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,126,925		4,126,925	0	4,126,925	90.00
91.00	09100	EMERGENCY	2,603,122		2,603,122	458	2,603,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,179,046		2,179,046		2,179,046	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	82,550,268	0	82,550,268	458	82,550,726	200.00
201.00		Less Observation Beds	2,179,046		2,179,046		2,179,046	201.00
202.00		Total (see instructions)	80,371,222	0	80,371,222	458	80,371,680	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 8:42 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,098,791		27,098,791			30.00
31.00	03100	INTENSIVE CARE UNIT	6,625,842		6,625,842			31.00
40.00	04000	SUBPROVIDER - IPF	8,639,317		8,639,317			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	5,582,978		5,582,978			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,670,371	89,538,155	104,208,526	0.078810	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,920,916	19,914,484	23,835,400	0.111571	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,943,175	26,837,528	30,780,703	0.012773	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,648,257	17,614,785	22,263,042	0.191182	0.000000	54.00
57.00	05700	CT SCAN	7,183,501	23,473,045	30,656,546	0.036733	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,593,458	17,581,231	19,174,689	0.067944	0.000000	58.00
60.00	06000	LABORATORY	10,644,704	20,707,382	31,352,086	0.115123	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	925,525	857,605	1,783,130	0.311060	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,320,079	9,368,732	11,688,811	0.130028	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	8,024,054	2,392,069	10,416,123	0.124046	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,703,735	615,714	7,319,449	0.260236	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,693,727	75,945	1,769,672	0.170043	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	414,988	36,048	451,036	0.129996	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,769	826,484	901,253	0.539534	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,581,449	25,513,107	35,094,556	0.234370	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,796,206	21,468,648	31,264,854	0.398623	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,672,879	20,613,964	32,286,843	0.176327	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	25,286	25,286	5.340109	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	315,308	782,526	1,097,834	0.056805	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,298,264	3,991,263	5,289,527	0.071726	0.000000	76.02
76.03	03140	CARDIOLOGY	8,672,237	9,599,203	18,271,440	0.072042	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	448	1,397,332	1,397,780	0.343832	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	941,234	16,765,684	17,706,918	0.233069	0.000000	90.00
91.00	09100	EMERGENCY	3,991,314	19,429,987	23,421,301	0.111143	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	740,545	4,005,479	4,746,024	0.459131	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	161,718,071	353,431,686	515,149,757			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	161,718,071	353,431,686	515,149,757			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 8:42 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
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.078810	50.00
51.00	05100	RECOVERY ROOM	0.111571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.012773	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191182	54.00
57.00	05700	CT SCAN	0.036733	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067944	58.00
60.00	06000	LABORATORY	0.115123	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.311060	63.00
64.00	06400	INTRAVENOUS THERAPY	0.130028	64.00
65.00	06500	RESPIRATORY THERAPY	0.124046	65.00
66.00	06600	PHYSICAL THERAPY	0.260236	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170043	67.00
68.00	06800	SPEECH PATHOLOGY	0.129996	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.539534	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.234370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.398623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176327	73.00
74.00	07400	RENAL DIALYSIS	5.340109	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056805	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.071726	76.02
76.03	03140	CARDIOLOGY	0.072042	76.03
76.97	07697	CARDIAC REHABILITATION	0.343832	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.233069	90.00
91.00	09100	EMERGENCY	0.111163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.459131	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,845,051		9,845,051	0	9,845,051	30.00
31.00	03100	INTENSIVE CARE UNIT	2,075,773		2,075,773	0	2,075,773	31.00
40.00	04000	SUBPROVIDER - IPF	2,895,233		2,895,233	0	2,895,233	40.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,393,427		2,393,427	0	2,393,427	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,212,700		8,212,700	0	8,212,700	50.00
51.00	05100	RECOVERY ROOM	2,659,344		2,659,344	0	2,659,344	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	393,175		393,175	0	393,175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,256,304		4,256,304	0	4,256,304	54.00
57.00	05700	CT SCAN	1,126,095		1,126,095	0	1,126,095	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,302,807		1,302,807	0	1,302,807	58.00
60.00	06000	LABORATORY	3,609,333		3,609,333	0	3,609,333	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	554,660		554,660	0	554,660	63.00
64.00	06400	INTRAVENOUS THERAPY	1,519,871		1,519,871	0	1,519,871	64.00
65.00	06500	RESPIRATORY THERAPY	1,292,083	0	1,292,083	0	1,292,083	65.00
66.00	06600	PHYSICAL THERAPY	1,904,783	0	1,904,783	0	1,904,783	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,921	0	300,921	0	300,921	67.00
68.00	06800	SPEECH PATHOLOGY	58,633	0	58,633	0	58,633	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486,257		486,257	0	486,257	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,225,097		8,225,097	0	8,225,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,462,894		12,462,894	0	12,462,894	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,693,042		5,693,042	0	5,693,042	73.00
74.00	07400	RENAL DIALYSIS	135,030		135,030	0	135,030	74.00
76.00	03950	ANCILLARY	0		0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,362		62,362	0	62,362	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	379,394		379,394	0	379,394	76.02
76.03	03140	CARDIOLOGY	1,316,304		1,316,304	0	1,316,304	76.03
76.97	07697	CARDIAC REHABILITATION	480,602		480,602	0	480,602	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,126,925		4,126,925	0	4,126,925	90.00
91.00	09100	EMERGENCY	2,603,122		2,603,122	458	2,603,580	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,179,046		2,179,046		2,179,046	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
200.00		Subtotal (see instructions)	82,550,268	0	82,550,268	458	82,550,726	200.00
201.00		Less Observation Beds	2,179,046		2,179,046		2,179,046	201.00
202.00		Total (see instructions)	80,371,222	0	80,371,222	458	80,371,680	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,098,791		27,098,791			30.00
31.00	03100	INTENSIVE CARE UNIT	6,625,842		6,625,842			31.00
40.00	04000	SUBPROVIDER - IPF	8,639,317		8,639,317			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	5,582,978		5,582,978			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,670,371	89,538,155	104,208,526	0.078810	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,920,916	19,914,484	23,835,400	0.111571	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,943,175	26,837,528	30,780,703	0.012773	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,648,257	17,614,785	22,263,042	0.191182	0.000000	54.00
57.00	05700	CT SCAN	7,183,501	23,473,045	30,656,546	0.036733	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,593,458	17,581,231	19,174,689	0.067944	0.000000	58.00
60.00	06000	LABORATORY	10,644,704	20,707,382	31,352,086	0.115123	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	925,525	857,605	1,783,130	0.311060	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	2,320,079	9,368,732	11,688,811	0.130028	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	8,024,054	2,392,069	10,416,123	0.124046	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,703,735	615,714	7,319,449	0.260236	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,693,727	75,945	1,769,672	0.170043	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	414,988	36,048	451,036	0.129996	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	74,769	826,484	901,253	0.539534	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,581,449	25,513,107	35,094,556	0.234370	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,796,206	21,468,648	31,264,854	0.398623	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,672,879	20,613,964	32,286,843	0.176327	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	25,286	25,286	5.340109	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0.000000	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	315,308	782,526	1,097,834	0.056805	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	1,298,264	3,991,263	5,289,527	0.071726	0.000000	76.02
76.03	03140	CARDIOLOGY	8,672,237	9,599,203	18,271,440	0.072042	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	448	1,397,332	1,397,780	0.343832	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	941,234	16,765,684	17,706,918	0.233069	0.000000	90.00
91.00	09100	EMERGENCY	3,991,314	19,429,987	23,421,301	0.111143	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	740,545	4,005,479	4,746,024	0.459131	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
200.00		Subtotal (see instructions)	161,718,071	353,431,686	515,149,757			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	161,718,071	353,431,686	515,149,757			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.078810	50.00
51.00	05100	RECOVERY ROOM	0.111571	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.012773	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191182	54.00
57.00	05700	CT SCAN	0.036733	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067944	58.00
60.00	06000	LABORATORY	0.115123	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.311060	63.00
64.00	06400	INTRAVENOUS THERAPY	0.130028	64.00
65.00	06500	RESPIRATORY THERAPY	0.124046	65.00
66.00	06600	PHYSICAL THERAPY	0.260236	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170043	67.00
68.00	06800	SPEECH PATHOLOGY	0.129996	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.539534	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.234370	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.398623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176327	73.00
74.00	07400	RENAL DIALYSIS	5.340109	74.00
76.00	03950	ANCILLARY	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056805	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.071726	76.02
76.03	03140	CARDIOLOGY	0.072042	76.03
76.97	07697	CARDIAC REHABILITATION	0.343832	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.233069	90.00
91.00	09100	EMERGENCY	0.111163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.459131	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,212,700	1,308,521	6,904,179	0	0	50.00
51.00	05100	RECOVERY ROOM	2,659,344	32,209	2,627,135	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	393,175	136,800	256,375	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,256,304	502,723	3,753,581	0	0	54.00
57.00	05700	CT SCAN	1,126,095	362,991	763,104	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,302,807	329,531	973,276	0	0	58.00
60.00	06000	LABORATORY	3,609,333	254,213	3,355,120	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	554,660	12,356	542,304	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	1,519,871	55,620	1,464,251	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,292,083	75,641	1,216,442	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,904,783	59,052	1,845,731	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	300,921	4,162	296,759	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,633	493	58,140	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486,257	84,709	401,548	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,225,097	229,385	7,995,712	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,462,894	215,156	12,247,738	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,693,042	107,703	5,585,339	0	0	73.00
74.00	07400	RENAL DIALYSIS	135,030	16,300	118,730	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,362	2,160	60,202	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	379,394	166,963	212,431	0	0	76.02
76.03	03140	CARDIOLOGY	1,316,304	118,161	1,198,143	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	480,602	24,840	455,762	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,126,925	216,971	3,909,954	0	0	90.00
91.00	09100	EMERGENCY	2,603,122	213,461	2,389,661	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,179,046	173,156	2,005,890	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
200.00		Subtotal (sum of lines 50 thru 199)	65,340,784	4,703,277	60,637,507	0	0	200.00
201.00		Less Observation Beds	2,179,046	173,156	2,005,890	0	0	201.00
202.00		Total (line 200 minus line 201)	63,161,738	4,530,121	58,631,617	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	8,212,700	104,208,526	0.078810		50.00
51.00	05100	RECOVERY ROOM	2,659,344	23,835,400	0.111571		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	393,175	30,780,703	0.012773		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,256,304	22,263,042	0.191182		54.00
57.00	05700	CT SCAN	1,126,095	30,656,546	0.036733		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,302,807	19,174,689	0.067944		58.00
60.00	06000	LABORATORY	3,609,333	31,352,086	0.115123		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	554,660	1,783,130	0.311060		63.00
64.00	06400	INTRAVENOUS THERAPY	1,519,871	11,688,811	0.130028		64.00
65.00	06500	RESPIRATORY THERAPY	1,292,083	10,416,123	0.124046		65.00
66.00	06600	PHYSICAL THERAPY	1,904,783	7,319,449	0.260236		66.00
67.00	06700	OCCUPATIONAL THERAPY	300,921	1,769,672	0.170043		67.00
68.00	06800	SPEECH PATHOLOGY	58,633	451,036	0.129996		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	486,257	901,253	0.539534		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,225,097	35,094,556	0.234370		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,462,894	31,264,854	0.398623		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,693,042	32,286,843	0.176327		73.00
74.00	07400	RENAL DIALYSIS	135,030	25,286	5.340109		74.00
76.00	03950	ANCILLARY	0	0	0.000000		76.00
76.01	03560	PULMONARY FUNCTION TESTING	62,362	1,097,834	0.056805		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	379,394	5,289,527	0.071726		76.02
76.03	03140	CARDIOLOGY	1,316,304	18,271,440	0.072042		76.03
76.97	07697	CARDIAC REHABILITATION	480,602	1,397,780	0.343832		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	4,126,925	17,706,918	0.233069		90.00
91.00	09100	EMERGENCY	2,603,122	23,421,301	0.111143		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,179,046	4,746,024	0.459131		92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0.000000		101.00
200.00		Subtotal (sum of lines 50 thru 199)	65,340,784	467,202,829			200.00
201.00		Less Observation Beds	2,179,046	0			201.00
202.00		Total (line 200 minus line 201)	63,161,738	467,202,829			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/25/2018 8:42 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	782,324	0	782,324	13,771	56.81	30.00
31.00	INTENSIVE CARE UNIT	161,640		161,640	1,397	115.71	31.00
40.00	SUBPROVIDER - IPF	180,568	0	180,568	3,762	48.00	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	201,692		201,692	6,278	32.13	44.00
200.00	Total (lines 30 through 199)	1,326,224		1,326,224	25,208		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	5,648	320,863				30.00
31.00	INTENSIVE CARE UNIT	707	81,807				31.00
40.00	SUBPROVIDER - IPF	2,438	117,024				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	3,701	118,913				44.00
200.00	Total (lines 30 through 199)	12,494	638,607				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,308,521	104,208,526	0.012557	6,959,681	87,393	50.00
51.00	05100	RECOVERY ROOM	32,209	23,835,400	0.001351	1,759,880	2,378	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	136,800	30,780,703	0.004444	1,856,530	8,250	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,723	22,263,042	0.022581	2,337,358	52,780	54.00
57.00	05700	CT SCAN	362,991	30,656,546	0.011841	3,835,093	45,411	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,531	19,174,689	0.017186	882,034	15,159	58.00
60.00	06000	LABORATORY	254,213	31,352,086	0.008108	4,894,637	39,686	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	12,356	1,783,130	0.006929	487,120	3,375	63.00
64.00	06400	INTRAVENOUS THERAPY	55,620	11,688,811	0.004758	1,224,197	5,825	64.00
65.00	06500	RESPIRATORY THERAPY	75,641	10,416,123	0.007262	3,232,415	23,474	65.00
66.00	06600	PHYSICAL THERAPY	59,052	7,319,449	0.008068	825,846	6,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,162	1,769,672	0.002352	297,250	699	67.00
68.00	06800	SPEECH PATHOLOGY	493	451,036	0.001093	178,753	195	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,709	901,253	0.093990	48,042	4,515	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,385	35,094,556	0.006536	4,954,079	32,380	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,156	31,264,854	0.006882	4,868,816	33,507	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,703	32,286,843	0.003336	5,090,081	16,981	73.00
74.00	07400	RENAL DIALYSIS	16,300	25,286	0.644625	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,160	1,097,834	0.001968	165,368	325	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	166,963	5,289,527	0.031565	687,078	21,688	76.02
76.03	03140	CARDIOLOGY	118,161	18,271,440	0.006467	3,774,302	24,408	76.03
76.97	07697	CARDIAC REHABILITATION	24,840	1,397,780	0.017771	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	216,971	17,706,918	0.012253	583,574	7,151	90.00
91.00	09100	EMERGENCY	213,461	23,421,301	0.009114	2,103,812	19,174	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	173,156	4,746,024	0.036484	413,249	15,077	92.00
200.00		Total (lines 50 through 199)	4,703,277	467,202,829		51,459,195	466,494	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	13,771	0.00	5,648	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,397	0.00	707	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,762	0.00	2,438	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	6,278	0.00	3,701	44.00
200.00		Total (lines 30 through 199)		0	25,208		12,494	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
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	104,208,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,835,400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,780,703	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,263,042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	30,656,546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,174,689	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,352,086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,783,130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,688,811	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,416,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,319,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,769,672	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	451,036	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	901,253	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,094,556	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,264,854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	25,286	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,097,834	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	5,289,527	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	18,271,440	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,397,780	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	17,706,918	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,421,301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,746,024	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	467,202,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,959,681	0	26,261,850	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,759,880	0	4,336,881	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,856,530	0	7,037,894	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,337,358	0	4,992,851	0	54.00
57.00	05700	CT SCAN	0.000000	3,835,093	0	7,750,594	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	882,034	0	4,684,977	0	58.00
60.00	06000	LABORATORY	0.000000	4,894,637	0	3,498,917	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	487,120	0	445,620	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	1,224,197	0	3,001,865	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	3,232,415	0	830,533	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	825,846	0	157,045	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	297,250	0	26,427	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	178,753	0	16,520	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	48,042	0	172,320	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,954,079	0	6,022,437	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,868,816	0	5,730,869	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,090,081	0	7,322,348	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	165,368	0	310,551	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	687,078	0	926,523	0	76.02
76.03	03140	CARDIOLOGY	0.000000	3,774,302	0	2,988,697	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	755,700	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	583,574	0	3,424,064	0	90.00
91.00	09100	EMERGENCY	0.000000	2,103,812	0	4,495,184	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	413,249	0	1,335,557	0	92.00
200.00		Total (lines 50 through 199)		51,459,195	0	96,526,224	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.078810	26,261,850	0	0	2,069,696	50.00
51.00	05100	RECOVERY ROOM	0.111571	4,336,881	0	0	483,870	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012773	7,037,894	0	0	89,895	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191182	4,992,851	0	0	954,543	54.00
57.00	05700	CT SCAN	0.036733	7,750,594	0	0	284,703	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067944	4,684,977	0	0	318,316	58.00
60.00	06000	LABORATORY	0.115123	3,498,917	0	0	402,806	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.311060	445,620	0	0	138,615	63.00
64.00	06400	INTRAVENOUS THERAPY	0.130028	3,001,865	0	0	390,327	64.00
65.00	06500	RESPIRATORY THERAPY	0.124046	830,533	0	0	103,024	65.00
66.00	06600	PHYSICAL THERAPY	0.260236	157,045	0	0	40,869	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170043	26,427	0	0	4,494	67.00
68.00	06800	SPEECH PATHOLOGY	0.129996	16,520	0	0	2,148	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.539534	172,320	0	0	92,972	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.234370	6,022,437	0	0	1,411,479	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.398623	5,730,869	34,192	0	2,284,456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176327	7,322,348	0	43,335	1,291,128	73.00
74.00	07400	RENAL DIALYSIS	5.340109	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056805	310,551	0	0	17,641	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.071726	926,523	0	0	66,456	76.02
76.03	03140	CARDIOLOGY	0.072042	2,988,697	0	0	215,312	76.03
76.97	07697	CARDIAC REHABILITATION	0.343832	755,700	0	0	259,834	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.233069	3,424,064	0	0	798,043	90.00
91.00	09100	EMERGENCY	0.111143	4,495,184	0	0	499,608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.459131	1,335,557	0	0	613,196	92.00
200.00		Subtotal (see instructions)		96,526,224	34,192	43,335	12,833,431	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		96,526,224	34,192	43,335	12,833,431	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,630	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,641		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	13,630	7,641		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,630	7,641		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,308,521	104,208,526	0.012557	0	0	50.00
51.00	05100	RECOVERY ROOM	32,209	23,835,400	0.001351	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	136,800	30,780,703	0.004444	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,723	22,263,042	0.022581	65,882	1,488	54.00
57.00	05700	CT SCAN	362,991	30,656,546	0.011841	147,282	1,744	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,531	19,174,689	0.017186	11,279	194	58.00
60.00	06000	LABORATORY	254,213	31,352,086	0.008108	292,183	2,369	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	12,356	1,783,130	0.006929	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	55,620	11,688,811	0.004758	22,857	109	64.00
65.00	06500	RESPIRATORY THERAPY	75,641	10,416,123	0.007262	197,916	1,437	65.00
66.00	06600	PHYSICAL THERAPY	59,052	7,319,449	0.008068	108,995	879	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,162	1,769,672	0.002352	9,074	21	67.00
68.00	06800	SPEECH PATHOLOGY	493	451,036	0.001093	13,340	15	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,709	901,253	0.093990	1,435	135	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,385	35,094,556	0.006536	44,069	288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,156	31,264,854	0.006882	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,703	32,286,843	0.003336	134,965	450	73.00
74.00	07400	RENAL DIALYSIS	16,300	25,286	0.644625	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,160	1,097,834	0.001968	4,040	8	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	166,963	5,289,527	0.031565	0	0	76.02
76.03	03140	CARDIOLOGY	118,161	18,271,440	0.006467	48,346	313	76.03
76.97	07697	CARDIAC REHABILITATION	24,840	1,397,780	0.017771	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	216,971	17,706,918	0.012253	24,700	303	90.00
91.00	09100	EMERGENCY	213,461	23,421,301	0.009114	154,254	1,406	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,746,024	0.000000	16,445	0	92.00
200.00		Total (lines 50 through 199)	4,530,121	467,202,829		1,297,062	11,159	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	104,208,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,835,400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,780,703	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,263,042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	30,656,546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,174,689	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,352,086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,783,130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,688,811	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,416,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,319,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,769,672	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	451,036	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	901,253	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,094,556	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,264,854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	25,286	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,097,834	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	5,289,527	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	18,271,440	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,397,780	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	17,706,918	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,421,301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,746,024	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	467,202,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	65,882	0	1,114	0	54.00
57.00	05700	CT SCAN	0.000000	147,282	0	6,480	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	11,279	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	292,183	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	22,857	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	197,916	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	108,995	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	9,074	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	13,340	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,435	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	44,069	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	134,965	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	4,040	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	48,346	0	758	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	24,700	0	2,015	0	90.00
91.00	09100	EMERGENCY	0.000000	154,254	0	2,084	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	16,445	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,297,062	0	12,451	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.078810	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.111571	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012773	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191182	1,114	0	0	213	54.00
57.00	05700	CT SCAN	0.036733	6,480	0	0	238	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067944	0	0	0	0	58.00
60.00	06000	LABORATORY	0.115123	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.311060	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.130028	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.124046	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.260236	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170043	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.129996	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.539534	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.234370	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.398623	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176327	0	0	5,080	0	73.00
74.00	07400	RENAL DIALYSIS	5.340109	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056805	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.071726	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.072042	758	0	0	55	76.03
76.97	07697	CARDIAC REHABILITATION	0.343832	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.233069	2,015	0	0	470	90.00
91.00	09100	EMERGENCY	0.111143	2,084	0	0	232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.459131	0	0	0	0	92.00
200.00		Subtotal (see instructions)		12,451	0	5,080	1,208	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		12,451	0	5,080	1,208	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	896		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	ANCILLARY	0	0		76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0		76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0		76.02
76.03	03140	CARDIOLOGY	0	0		76.03
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	896		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	896		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	104,208,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,835,400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,780,703	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,263,042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	30,656,546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,174,689	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,352,086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,783,130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,688,811	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,416,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,319,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,769,672	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	451,036	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	901,253	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,094,556	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,264,854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	25,286	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,097,834	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	5,289,527	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	18,271,440	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,397,780	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	17,706,918	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,421,301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,746,024	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	467,202,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	74,787	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	462,589	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	18,294	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	2,027	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,065,290	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,210,050	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,387,403	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	95,395	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	9,361	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	327,714	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	7,130	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	9,331	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	58,544	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,727,915	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | 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	782,324	0	782,324	13,771	56.81	30.00
31.00	INTENSIVE CARE UNIT	161,640		161,640	1,397	115.71	31.00
40.00	SUBPROVIDER - IPF	180,568	0	180,568	3,762	48.00	40.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	201,692		201,692	6,278	32.13	44.00
200.00	Total (lines 30 through 199)	1,326,224		1,326,224	25,208		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	776	44,085				30.00
31.00	INTENSIVE CARE UNIT	36	4,166				31.00
40.00	SUBPROVIDER - IPF	0	0				40.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
200.00	Total (lines 30 through 199)	812	48,251				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,308,521	104,208,526	0.012557	0	0	50.00
51.00	05100	RECOVERY ROOM	32,209	23,835,400	0.001351	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	136,800	30,780,703	0.004444	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,723	22,263,042	0.022581	0	0	54.00
57.00	05700	CT SCAN	362,991	30,656,546	0.011841	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,531	19,174,689	0.017186	0	0	58.00
60.00	06000	LABORATORY	254,213	31,352,086	0.008108	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	12,356	1,783,130	0.006929	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	55,620	11,688,811	0.004758	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	75,641	10,416,123	0.007262	0	0	65.00
66.00	06600	PHYSICAL THERAPY	59,052	7,319,449	0.008068	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,162	1,769,672	0.002352	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	493	451,036	0.001093	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,709	901,253	0.093990	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,385	35,094,556	0.006536	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,156	31,264,854	0.006882	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,703	32,286,843	0.003336	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,300	25,286	0.644625	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,160	1,097,834	0.001968	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	166,963	5,289,527	0.031565	0	0	76.02
76.03	03140	CARDIOLOGY	118,161	18,271,440	0.006467	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	24,840	1,397,780	0.017771	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	216,971	17,706,918	0.012253	0	0	90.00
91.00	09100	EMERGENCY	213,461	23,421,301	0.009114	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	173,156	4,746,024	0.036484	0	0	92.00
200.00		Total (lines 50 through 199)	4,703,277	467,202,829		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	13,771	0.00	776	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,397	0.00	36	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,762	0.00	0	40.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	6,278	0.00	0	44.00
200.00		Total (lines 30 through 199)		0	25,208		812	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
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	104,208,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,835,400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,780,703	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,263,042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	30,656,546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,174,689	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,352,086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,783,130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,688,811	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,416,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,319,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,769,672	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	451,036	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	901,253	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,094,556	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,264,854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	25,286	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,097,834	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	5,289,527	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	18,271,440	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,397,780	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	17,706,918	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,421,301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,746,024	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	467,202,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,308,521	104,208,526	0.012557	0	0	50.00
51.00	05100	RECOVERY ROOM	32,209	23,835,400	0.001351	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	136,800	30,780,703	0.004444	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,723	22,263,042	0.022581	0	0	54.00
57.00	05700	CT SCAN	362,991	30,656,546	0.011841	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	329,531	19,174,689	0.017186	0	0	58.00
60.00	06000	LABORATORY	254,213	31,352,086	0.008108	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	12,356	1,783,130	0.006929	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	55,620	11,688,811	0.004758	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	75,641	10,416,123	0.007262	0	0	65.00
66.00	06600	PHYSICAL THERAPY	59,052	7,319,449	0.008068	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,162	1,769,672	0.002352	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	493	451,036	0.001093	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	84,709	901,253	0.093990	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	229,385	35,094,556	0.006536	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	215,156	31,264,854	0.006882	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,703	32,286,843	0.003336	0	0	73.00
74.00	07400	RENAL DIALYSIS	16,300	25,286	0.644625	0	0	74.00
76.00	03950	ANCILLARY	0	0	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	2,160	1,097,834	0.001968	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	166,963	5,289,527	0.031565	0	0	76.02
76.03	03140	CARDIOLOGY	118,161	18,271,440	0.006467	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	24,840	1,397,780	0.017771	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	216,971	17,706,918	0.012253	0	0	90.00
91.00	09100	EMERGENCY	213,461	23,421,301	0.009114	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,746,024	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,530,121	467,202,829		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	104,208,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,835,400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,780,703	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,263,042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	30,656,546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,174,689	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,352,086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,783,130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,688,811	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,416,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,319,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,769,672	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	451,036	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	901,253	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,094,556	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,264,854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	25,286	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,097,834	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	5,289,527	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	18,271,440	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,397,780	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	17,706,918	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,421,301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,746,024	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	467,202,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	ANCILLARY	0	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013
Component CCN: 14-5579

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

Worksheet D
Part IV
Date/Time Prepared:
5/25/2018 8:42 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	104,208,526	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	23,835,400	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	30,780,703	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,263,042	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	30,656,546	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	19,174,689	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	31,352,086	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	1,783,130	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	11,688,811	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,416,123	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,319,449	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,769,672	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	451,036	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	901,253	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	35,094,556	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	31,264,854	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	32,286,843	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	25,286	0.000000	74.00
76.00	03950	ANCILLARY	0	0	0	0	0.000000	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0	0	0	1,097,834	0.000000	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0	0	0	5,289,527	0.000000	76.02
76.03	03140	CARDIOLOGY	0	0	0	18,271,440	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,397,780	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	17,706,918	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	23,421,301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	4,746,024	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	467,202,829		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0013
Component CCN: 14-5579

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

Worksheet D
Part IV
Date/Time Prepared:
5/25/2018 8:42 am

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.000000	0	0	0	0	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03140	CARDIOLOGY	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,771	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,771	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	10,723	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)	5,648	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,845,051	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)	9,845,051	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,845,051	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	714.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,037,812	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	4,037,812	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,075,773	1,397	1,485.88	707	1,050,517	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,895,620	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	12,983,949	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)	402,670	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	466,494	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	869,164	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	12,114,785	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,048	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	714.91	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,179,046	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	782,324	9,845,051	0.079464	2,179,046	173,156	90.00
91.00	Nursing School cost	0	9,845,051	0.000000	2,179,046	0	91.00
92.00	Allied health cost	0	9,845,051	0.000000	2,179,046	0	92.00
93.00	All other Medical Education	0	9,845,051	0.000000	2,179,046	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,762	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)	3,762	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,438	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,895,233	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)	2,895,233	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,895,233	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	769.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,876,285	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,876,285	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	180,638	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,056,923	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)	117,024	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	11,159	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	128,183	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,928,740	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: 14-0013 Component CCN: 14-S013	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	180,568	2,895,233	0.062367	0	0	90.00
91.00	Nursing School cost	0	2,895,233	0.000000	0	0	91.00
92.00	Allied health cost	0	2,895,233	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,895,233	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,278	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,278	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)	6,278	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,701	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,393,427	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)	2,393,427	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,393,427	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,393,427	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	381.24	71.00
72.00	Program routine service cost (line 9 x line 71)	1,410,969	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,410,969	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,410,969	83.00
84.00	Program inpatient ancillary services (see instructions)	1,103,808	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,514,777	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: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	13,771	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,771	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	10,723	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)	776	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,845,051	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)	9,845,051	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9,845,051	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	714.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	554,770	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)	554,770	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,075,773	1,397	1,485.88	36	53,492	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	608,262	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)	48,251	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)	48,251	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	560,011	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,048	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	714.91	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,179,046	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	782,324	9,845,051	0.079464	2,179,046	173,156	90.00
91.00	Nursing School cost	0	9,845,051	0.000000	2,179,046	0	91.00
92.00	Allied health cost	0	9,845,051	0.000000	2,179,046	0	92.00
93.00	All other Medical Education	0	9,845,051	0.000000	2,179,046	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 8:42 am
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,762	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)	3,762	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,895,233	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)	2,895,233	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,895,233	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	769.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	0	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)	0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	0	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: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	180,568	2,895,233	0.062367	0	0	90.00
91.00	Nursing School cost	0	2,895,233	0.000000	0	0	91.00
92.00	Allied health cost	0	2,895,233	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,895,233	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 8:42 am
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,278	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,278	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)	6,278	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,393,427	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)	2,393,427	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,393,427	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/25/2018 8:42 am

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,393,427	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	381.24	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	201,692	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	32.13	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	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: 14-0013 Component CCN: 14-5579	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/25/2018 8:42 am
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		14,569,064		30.00
31.00	03100	INTENSIVE CARE UNIT		3,516,062		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.078810	6,959,681	548,492	50.00
51.00	05100	RECOVERY ROOM	0.111571	1,759,880	196,352	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012773	1,856,530	23,713	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191182	2,337,358	446,861	54.00
57.00	05700	CT SCAN	0.036733	3,835,093	140,874	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067944	882,034	59,929	58.00
60.00	06000	LABORATORY	0.115123	4,894,637	563,485	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.311060	487,120	151,524	63.00
64.00	06400	INTRAVENOUS THERAPY	0.130028	1,224,197	159,180	64.00
65.00	06500	RESPIRATORY THERAPY	0.124046	3,232,415	400,968	65.00
66.00	06600	PHYSICAL THERAPY	0.260236	825,846	214,915	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170043	297,250	50,545	67.00
68.00	06800	SPEECH PATHOLOGY	0.129996	178,753	23,237	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.539534	48,042	25,920	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.234370	4,954,079	1,161,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.398623	4,868,816	1,940,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176327	5,090,081	897,519	73.00
74.00	07400	RENAL DIALYSIS	5.340109	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056805	165,368	9,394	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.071726	687,078	49,281	76.02
76.03	03140	CARDIOLOGY	0.072042	3,774,302	271,908	76.03
76.97	07697	CARDIAC REHABILITATION	0.343832	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.233069	583,574	136,013	90.00
91.00	09100	EMERGENCY	0.111163	2,103,812	233,866	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.459131	413,249	189,735	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		51,459,195	7,895,620	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)		51,459,195		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		5,573,962		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.078810	0	0	50.00
51.00	05100	RECOVERY ROOM	0.111571	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012773	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191182	65,882	12,595	54.00
57.00	05700	CT SCAN	0.036733	147,282	5,410	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067944	11,279	766	58.00
60.00	06000	LABORATORY	0.115123	292,183	33,637	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.311060	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.130028	22,857	2,972	64.00
65.00	06500	RESPIRATORY THERAPY	0.124046	197,916	24,551	65.00
66.00	06600	PHYSICAL THERAPY	0.260236	108,995	28,364	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170043	9,074	1,543	67.00
68.00	06800	SPEECH PATHOLOGY	0.129996	13,340	1,734	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.539534	1,435	774	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.234370	44,069	10,328	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.398623	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176327	134,965	23,798	73.00
74.00	07400	RENAL DIALYSIS	5.340109	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056805	4,040	229	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.071726	0	0	76.02
76.03	03140	CARDIOLOGY	0.072042	48,346	3,483	76.03
76.97	07697	CARDIAC REHABILITATION	0.343832	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.233069	24,700	5,757	90.00
91.00	09100	EMERGENCY	0.111163	154,254	17,147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.459131	16,445	7,550	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,297,062	180,638	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)		1,297,062		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.078810	0	0	50.00
51.00	05100	RECOVERY ROOM	0.111571	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.012773	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.191182	74,787	14,298	54.00
57.00	05700	CT SCAN	0.036733	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.067944	0	0	58.00
60.00	06000	LABORATORY	0.115123	462,589	53,255	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.311060	18,294	5,691	63.00
64.00	06400	INTRAVENOUS THERAPY	0.130028	2,027	264	64.00
65.00	06500	RESPIRATORY THERAPY	0.124046	1,065,290	132,145	65.00
66.00	06600	PHYSICAL THERAPY	0.260236	2,210,050	575,135	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.170043	1,387,403	235,918	67.00
68.00	06800	SPEECH PATHOLOGY	0.129996	95,395	12,401	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.539534	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.234370	9,361	2,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.398623	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.176327	327,714	57,785	73.00
74.00	07400	RENAL DIALYSIS	5.340109	0	0	74.00
76.00	03950	ANCILLARY	0.000000	0	0	76.00
76.01	03560	PULMONARY FUNCTION TESTING	0.056805	7,130	405	76.01
76.02	03340	GASTRO INTESTINAL SERVICES	0.071726	0	0	76.02
76.03	03140	CARDIOLOGY	0.072042	9,331	672	76.03
76.97	07697	CARDIAC REHABILITATION	0.343832	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.233069	58,544	13,645	90.00
91.00	09100	EMERGENCY	0.111143	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.459131	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,727,915	1,103,808	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)		5,727,915		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	9,017,089	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,341,654	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	153,531	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	101.65	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.73	30.00
31.00	Percentage of Medicaid patient days (see instructions)	6.68	31.00
32.00	Sum of lines 30 and 31	7.41	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,163	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	12,512,274		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	12,512,274	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,018,071	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	13,530,345	59.00
60.00	Primary payer payments	8,582	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	13,521,763	61.00
62.00	Deductibles billed to program beneficiaries	1,615,628	62.00
63.00	Coinsurance billed to program beneficiaries	5,922	63.00
64.00	Allowable bad debts (see instructions)	228,561	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	148,565	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	12,048,778	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-59,353	70.93
70.94	HRR adjustment amount (see instructions)	-213,818	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,775,607	71.00
71.01	Sequestration adjustment (see instructions)		235,512	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		11,475,016	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		65,079	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,017,089	0	9,017,089		9,017,089	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,341,654	0		3,341,654	3,341,654	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	153,531	0	132,328	21,204	153,532	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,512,274	0	9,149,416	3,362,858	12,512,274	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,512,274	0	9,149,416	3,362,858	12,512,274	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,018,071	0	742,630	275,441	1,018,071	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/25/2018 8:42 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,892,046	3,638,299	13,530,345	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	993,437	0	723,376	270,061	993,437	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,633	0	8,331	1,302	9,633	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0151	0.0151	0.0151	0.0151		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	15,001	0	10,923	4,078	15,001	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,018,071	0	742,630	275,441	1,018,071	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	9,017,089	9,017,089		9,017,089	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,341,654		3,341,654	3,341,654	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	153,531	132,328	21,204	153,532	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	12,512,274	9,149,416	3,362,858	12,512,274	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	12,512,274	9,149,416	3,362,858	12,512,274	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,018,071	742,630	275,441	1,018,071	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			9,892,046	3,638,299	13,530,345	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2018 8:42 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	993,437	723,376	270,061	993,437	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	9,633	8,331	1,302	9,633	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0151	0.0151	0.0151		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	15,001	10,923	4,078	15,001	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,018,071	742,630	275,441	1,018,071	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-59,353	-46,940	-12,413	-59,353	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-213,818	-137,962	-75,856	-213,818	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	21,271	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,833,431	2.00
3.00	OPPS payments	12,264,157	3.00
4.00	Outlier payment (see instructions)	109,458	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)	21,271	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	77,527	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)	77,527	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	77,527	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	56,256	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)	21,271	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)	12,373,615	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	6,838	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,281,791	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)	10,106,257	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)	10,106,257	30.00
31.00	Primary payer payments	5,195	31.00
32.00	Subtotal (line 30 minus line 31)	10,101,062	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	252,075	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	163,849	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	10,264,911	37.00
38.00	MSP-LCC reconciliation amount from PS&R	19	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)	10,264,892	40.00
40.01	Sequestration adjustment (see instructions)	205,298	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	9,980,545	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	79,049	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	896	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,208	2.00
3.00	OPPS payments	1,890	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)	896	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,080	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)	5,080	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	5,080	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,184	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)	896	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)	1,890	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	177	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,609	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,609	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,609	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,609	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)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,609	40.00
40.01	Sequestration adjustment (see instructions)	52	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	3,306	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-749	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 8:42 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		11,482,574		9,965,534	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	08/03/2017	15,011	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	08/03/2017	7,558		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)		-7,558		15,011	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)		11,475,016		9,980,545	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		65,079		79,049	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		11,540,095		10,059,594	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013 | Component CCN: 14-S013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,839,629		3,306	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,839,629		3,306	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		36,083		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		749	6.02
7.00	Total Medicare program liability (see instructions)		1,875,712		2,557	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0013 | Component CCN: 14-5579 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2018 8:42 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,759,738		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,759,738		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		6,665		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,766,403		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013 Component CCN: 14-S013	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,112,012	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 instuctions)	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 instuctions)	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)	10.306849	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,112,012	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)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,112,012	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,112,012	18.00
19.00	Deductibles	178,892	19.00
20.00	Subtotal (line 18 minus line 19)	1,933,120	20.00
21.00	Coinsurance	55,930	21.00
22.00	Subtotal (line 20 minus line 21)	1,877,190	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	56,619	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	36,802	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,913,992	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)	1,913,992	31.00
31.01	Sequestration adjustment (see instructions)	38,280	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,839,629	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)	36,083	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0013 Component CCN: 14-5579	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VI Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,905,033	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,905,033	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	109,382	7.00
8.00	Allowable bad debts (see instructions)	10,463	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	6,801	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1,802,452	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	1,802,452	15.00
15.01	Sequestration adjustment (see instructions)	36,049	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	1,759,738	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	6,665	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/25/2018 8:42 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,467,610	0	0	0	1.00
2.00	Temporary investments	272,086	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,999,986	0	0	0	4.00
5.00	Other receivable	3,224,305	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,404,479	0	0	0	7.00
8.00	Prepaid expenses	523,084	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	12,016,041	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	41,907,591	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	6,081,907	0	0	0	12.00
13.00	Land improvements	6,433,463	0	0	0	13.00
14.00	Accumulated depreciation	-11,730,238	0	0	0	14.00
15.00	Buildings	69,155,390	0	0	0	15.00
16.00	Accumulated depreciation	-87,694,578	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	20,212,096	0	0	0	19.00
20.00	Accumulated depreciation	-35,894,589	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	164,588,581	0	0	0	23.00
24.00	Accumulated depreciation	-92,015,705	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)	39,136,327	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	6,268,087	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	7,021,544	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,289,631	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	94,333,549	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,899,004	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,192,293	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				42.00
43.00	Due to other funds	14,239,069	0	0	0	43.00
44.00	Other current liabilities	2,894,585	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,224,951	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	31,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	38,653,562	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	38,684,562	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	61,909,513	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	32,424,036				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	32,424,036	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	94,333,549	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/25/2018 8:42 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		9,876,540		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		23,037,790				2.00
3.00	Total (sum of line 1 and line 2)		32,914,330		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CHANGES IN UNRESTRICTED FUND	38,784		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		38,784		0		10.00
11.00	Subtotal (line 3 plus line 10)		32,953,114		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	CHANGE IN TEMP & PERM REST	529,079		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		529,079		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		32,424,035		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	CHANGES IN UNRESTRICTED FUND		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00	CHANGE IN TEMP & PERM REST		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: 14-0013 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/25/2018 8:42 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	27,761,082		27,761,082	1.00
2.00	SUBPROVIDER - IPF	8,637,721		8,637,721	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	11,819,655		11,819,655	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	48,218,458		48,218,458	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,769,477		6,769,477	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)	6,769,477		6,769,477	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	54,987,935		54,987,935	17.00
18.00	Ancillary services	107,792,416	0	107,792,416	18.00
19.00	Outpatient services	0	360,320,921	360,320,921	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		0	0	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)	162,780,351	360,320,921	523,101,272	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		73,172,371		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	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		73,172,371		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/25/2018 8:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	523,101,272	1.00
2.00	Less contractual allowances and discounts on patients' accounts	406,640,904	2.00
3.00	Net patient revenues (line 1 minus line 2)	116,460,368	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	73,172,371	4.00
5.00	Net income from service to patients (line 3 minus line 4)	43,287,997	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	34,326	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	507,682	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 PROCTOR & HOME OFFICE REVENUE	4,502,899	24.00
25.00	Total other income (sum of lines 6-24)	5,044,907	25.00
26.00	Total (line 5 plus line 25)	48,332,904	26.00
27.00	PEORIA HOME OFFICE EXPENSES	25,295,114	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	25,295,114	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	23,037,790	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0013	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/25/2018 8:42 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	993,437	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	9,633	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	33.33	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.73	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	6.68	8.00
9.00	Sum of lines 7 and 8	7.41	9.00
10.00	Allowable disproportionate share percentage (see instructions)	1.51	10.00
11.00	Disproportionate share adjustment (see instructions)	15,001	11.00
12.00	Total prospective capital payments (see instructions)	1,018,071	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00