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: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/22/2018 1:07 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/22/2018 Time: 1:07 pm
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 SSM HEALTH ST. MARY'S HOSPITAL (14-0034) 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.

[X] 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) KAREN REWERTS
Officer or Administrator of Provider(s)

SYSTEM VICE PRESIDENT
Title

(Dated when report is electronically signed.)
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	149,118	232,120	0	0	1.00
2.00	Subprovider - IPF	0	72,447	1		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
12.20	OPT I	0		0		0	12.20
200.00	Total	0	221,565	232,121	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 400 NORTH PLEASANT AVENUE	PO Box:			1.00
2.00	City: CENTRALIA	State: IL	Zip Code: 62801-	County: MARION	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	SSM HEALTH ST. MARY'S HOSPITAL	140034	99914	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	SSM HEALTH ST. MARYS PSYCH	14S034	99914	4	01/01/2002	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									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
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I	ST MARYS WORK SAFETY INSTITUTE	146668	99914		03/08/2000	N	O	N	17.20
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)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,399	247	0	0	332	121	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		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	
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

		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.	2		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.	2		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.	1		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	01/01/2017	12/31/2017	38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		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)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		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	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

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		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		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.			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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		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.	Y			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.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	51,150	8,268	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	Y	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	269020	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

	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: SSM HEALTH	Contractor's Name: A	Contractor's Number: 05301	141.00
142.00	Street: 10101 WOODFIELD LANE	PO Box:		142.00
143.00	City: ST. LOUIS	State: MO	Zip Code: 63132	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
161.10	CORF		N	N	N	161.10
161.20	OPT		N	N	N	161.20

		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)	9.99	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)	08/02/2017	10/30/2017	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2018 12:29 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/03/2017	Y	04/03/2017	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.	Y		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.	ERIC	LAMOND	41.00
42.00	Enter the employer/company name of the cost report preparer.	SSM HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-989-3162	ERIC.LAMOND@SSMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/18/2018 12:29 pm

		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.	MANAGER - GOVERNEMENT REIMBURSEMENT		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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

	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	82	29,930	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)		82	29,930	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	12	4,380	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		94	34,310	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	24	8,760		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
25.20	CMHC - OPT	99.20				0	25.20
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)		118				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

	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)	9,377	1,677	13,567			1.00
2.00	HMO and other (see instructions)	1,128	579				2.00
3.00	HMO IPF Subprovider	0	258				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)	9,377	1,677	13,567			7.00
8.00	INTENSIVE CARE UNIT	980	399	2,149			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		323	478			13.00
14.00	Total (see instructions)	10,357	2,399	16,194	0.00	587.26	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,388	2,315	4,747	0.00	35.62	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OPT	0	0	0	0.00	0.00	25.20
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	622.88	27.00
28.00	Observation Bed Days		482	2,174			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			136			30.00
31.00	Employee discount days - IRF			16			31.00
32.00	Labor & delivery days (see instructions)	0	121	146			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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

	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	2,533	846	4,411	1.00
2.00	HMO and other (see instructions)			285	96		2.00
3.00	HMO IPF Subprovider				68		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	2,533	846	4,411	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	228	553	1,062	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OPT	0.00					25.20
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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/18/2018 12:29 pm

		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	34,646,096	1	34,646,097	1,295,574.60	26.74	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		210,442	0	210,442	2,484.32	84.71	3.00
4.00	Physician-Part A - Administrative		194,585	0	194,585	1,078.00	180.51	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		677,828	0	677,828	6,778.00	100.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,124,663	29,061	2,153,724	8,311.84	259.12	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		653,726	0	653,726	10,683.24	61.19	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		408,103	0	408,103	4,080.53	100.01	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		4,352,566	0	4,352,566	124,468.32	34.97	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		15,878,258	0	15,878,258			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		86,481	0	86,481			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		21,051	0	21,051			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		1,069	0	1,069			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)		1,541,149	0	1,541,149			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)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	128,318	0	128,318	0.00	0.00	26.00
27.00	Administrative & General	5.00	3,170,543	-29,061	3,141,482	98,620.93	31.85	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/18/2018 12:29 pm

		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.)		457,738	0	457,738	2,930.21	156.21	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	748,317	0	748,317	33,057.42	22.64	30.00
31.00	Laundry & Linen Service	8.00	115,437	0	115,437	8,189.76	14.10	31.00
32.00	Housekeeping	9.00	1,010,856	0	1,010,856	74,209.79	13.62	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	808,910	-555,211	253,699	16,460.77	15.41	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	555,211	555,211	36,023.77	15.41	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	792,965	0	792,965	23,438.13	33.83	38.00
39.00	Central Services and Supply	14.00	274,665	-153,417	121,248	2,414.89	50.21	39.00
40.00	Pharmacy	15.00	1,208,304	0	1,208,304	31,691.63	38.13	40.00
41.00	Medical Records & Medical Records Library	16.00	535,624	0	535,624	27,474.65	19.50	41.00
42.00	Social Service	17.00	751,366	0	751,366	23,787.75	31.59	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/18/2018 12:29 pm

		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)		34,215,564	1	34,215,565	1,289,242.49	26.54	1.00
2.00	Excluded area salaries (see instructions)		2,124,663	29,061	2,153,724	8,311.84	259.12	2.00
3.00	Subtotal salaries (line 1 minus line 2)		32,090,901	-29,060	32,061,841	1,280,930.65	25.03	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,414,395	0	5,414,395	139,232.09	38.89	4.00
5.00	Subtotal wage-related costs (see inst.)		17,440,458	0	17,440,458	0.00	54.40	5.00
6.00	Total (sum of lines 3 thru 5)		54,945,754	-29,060	54,916,694	1,420,162.74	38.67	6.00
7.00	Total overhead cost (see instructions)		10,003,043	-182,478	9,820,565	378,299.70	25.96	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/18/2018 12:29 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	522,641	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,112,169	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	7,028,807	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	177,400	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)	182,801	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	257,760	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	2,506,941	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	68,606	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	963,962	22.00
23.00	Tuition Reimbursement	165,771	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,986,858	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/18/2018 12:29 pm

	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	653,726	16,069,608	1.00
2.00	Hospital	653,726	15,878,258	2.00
3.00	Subprovider - IPF	0	86,481	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	104,869	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-5 | Date/Time Prepared: 5/18/2018 12:29 pm

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	0	0					5.00
6.00	Number of stations	0	0	0	0			6.00
7.00	Treatment capacity per day per station	0	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00

		Y/N	
		1.00	
	ESRD PPS		
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	Y	10.02

		Prior to 1/1	After 12/31	
		1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	0	10.03
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list	0		11.00
12.00	Number of patients transplanted during the cost reporting period	0		12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

		MCP	INITIAL METHOD	
		1.00	2.00	
	PHYSICIAN PAYMENT METHOD			
21.00	Enter "X" if method(s) is applicable	X		21.00

		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1.00	2.00	3.00	4.00	5.00	
	ESAs						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA	Provider CCN: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet S-5 Date/Time Prepared: 5/18/2018 12:29 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/18/2018 12:29 pm

		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)	0.266645	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	12,777,907	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	5,065,339	5.00
6.00	Medicaid charges	82,589,553	6.00
7.00	Medicaid cost (line 1 times line 6)	22,022,091	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)	4,178,845	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)	4,178,845	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)	3,534,125	1,061,874	4,595,999	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	942,357	1,061,874	2,004,231	21.00
22.00	Payments received from patients for amounts previously written off as charity care	104,368	62,471	166,839	22.00
23.00	Cost of charity care (line 21 minus line 22)	837,989	999,403	1,837,392	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)	3,920,908	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	852,940	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,312,215	27.01
28.00	Non-Medicare bad debt expense (see instructions)	2,608,693	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,154,870	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,992,262	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,171,107	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/18/2018 12:29 pm

		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		4,145,413	4,145,413	230,409	4,375,822	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,105,111	2,105,111	0	2,105,111	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	128,318	13,495,174	13,623,492	0	13,623,492	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,170,543	17,479,047	20,649,590	-205,470	20,444,120	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	748,317	4,149,625	4,897,942	214,619	5,112,561	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115,437	332,860	448,297	-7,274	441,023	8.00
9.00	00900	HOUSEKEEPING	1,010,856	263,377	1,274,233	-101,307	1,172,926	9.00
10.00	01000	DIETARY	808,910	656,138	1,465,048	-1,005,564	459,484	10.00
11.00	01100	CAFETERIA	0	0	0	1,005,564	1,005,564	11.00
13.00	01300	NURSING ADMINISTRATION	792,965	105,275	898,240	0	898,240	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	274,665	216,571	491,236	-231,091	260,145	14.00
15.00	01500	PHARMACY	1,208,304	3,829,003	5,037,307	-3,598,477	1,438,830	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	535,624	193,099	728,723	0	728,723	16.00
17.00	01700	SOCIAL SERVICE	751,366	277,676	1,029,042	-434	1,028,608	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,142,834	1,181,385	8,324,219	-1,543,081	6,781,138	30.00
31.00	03100	INTENSIVE CARE UNIT	1,776,559	818,895	2,595,454	-190,768	2,404,686	31.00
40.00	04000	SUBPROVIDER - IPF	1,969,086	83,550	2,052,636	-8,628	2,044,008	40.00
43.00	04300	NURSERY	0	0	0	126,193	126,193	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,799,134	2,880,821	4,679,955	-1,926,306	2,753,649	50.00
51.00	05100	RECOVERY ROOM	333,032	18,946	351,978	-7,419	344,559	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	890,930	890,930	52.00
53.00	05300	ANESTHESIOLOGY	218,933	2,824,482	3,043,415	-110,338	2,933,077	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,165,092	861,479	2,026,571	-44,467	1,982,104	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	482,538	191,649	674,187	-2,106	672,081	55.00
56.00	05600	RADIOISOTOPE	168,723	463,134	631,857	-3,070	628,787	56.00
57.00	05700	CT SCAN	329,264	72,283	401,547	-45,384	356,163	57.00
58.00	05800	MRI	152,853	42,353	195,206	-30,633	164,573	58.00
59.00	05900	CARDIAC CATHETERIZATION	169,461	177,303	346,764	-132,656	214,108	59.00
60.00	06000	LABORATORY	1,686,628	2,602,674	4,289,302	-64,459	4,224,843	60.00
64.00	06400	INTRAVENOUS THERAPY	233,687	68,980	302,667	-43,734	258,933	64.00
65.00	06500	RESPIRATORY THERAPY	998,738	203,726	1,202,464	66,191	1,268,655	65.00
66.00	06600	PHYSICAL THERAPY	1,202,276	392,048	1,594,324	-18,223	1,576,101	66.00
66.01	06601	CLINICAL NUTRITION	179,135	1,328	180,463	0	180,463	66.01
67.00	06700	OCCUPATIONAL THERAPY	136,960	2,135	139,095	-1,378	137,717	67.00
68.00	06800	SPEECH PATHOLOGY	100,814	5,193	106,007	308	106,315	68.00
69.00	06900	ELECTROCARDIOLOGY	732,975	711,017	1,443,992	-17,524	1,426,468	69.00
69.01	06901	CARDIAC REHABILITATION	86,100	1,437	87,537	-419	87,118	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	125,963	277,866	403,829	-2,678	401,151	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,140,560	3,140,560	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	739,048	739,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,598,477	3,598,477	73.00
74.00	07400	RENAL DIALYSIS	0	130,821	130,821	-1,114	129,707	74.00
76.00	03330	ENDOSCOPY	396,670	160,398	557,068	-110,612	446,456	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,227,417	682,659	1,910,076	-96,123	1,813,953	90.00
91.00	09100	EMERGENCY	2,130,342	1,836,537	3,966,879	-349,884	3,616,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,490,519	63,941,468	98,431,987	111,678	98,543,665	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	32,998	2,156	35,154	-4	35,150	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	82,907	82,907	-132,640	-49,733	192.00
194.00	07950	NONREIMBURSABLE	122,579	130,064	252,643	20,966	273,609	194.00
194.01	07951	RETAIL PHARMACY	0	122,089	122,089	0	122,089	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	34,646,096	64,278,684	98,924,780	0	98,924,780	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/18/2018 12:29 pm

		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	284,586	4,660,408		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	454,456	2,559,567		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-4,818,690	8,804,802		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,903,460	14,540,660		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-26,394	5,086,167		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	441,023		8.00
9.00	00900	HOUSEKEEPING	-154	1,172,772		9.00
10.00	01000	DIETARY	-97,728	361,756		10.00
11.00	01100	CAFETERIA	-80	1,005,484		11.00
13.00	01300	NURSING ADMINISTRATION	-4,577	893,663		13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	260,145		14.00
15.00	01500	PHARMACY	-37,220	1,401,610		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,172	727,551		16.00
17.00	01700	SOCIAL SERVICE	0	1,028,608		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-726,353	6,054,785		30.00
31.00	03100	INTENSIVE CARE UNIT	-125	2,404,561		31.00
40.00	04000	SUBPROVIDER - IPF	-382	2,043,626		40.00
43.00	04300	NURSERY	0	126,193		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-3,090	2,750,559		50.00
51.00	05100	RECOVERY ROOM	0	344,559		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	890,930		52.00
53.00	05300	ANESTHESIOLOGY	-2,602,598	330,479		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-924,303	1,057,801		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-36,000	636,081		55.00
56.00	05600	RADIOISOTOPE	-23,430	605,357		56.00
57.00	05700	CT SCAN	0	356,163		57.00
58.00	05800	MRI	0	164,573		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	214,108		59.00
60.00	06000	LABORATORY	-309	4,224,534		60.00
64.00	06400	INTRAVENOUS THERAPY	-42	258,891		64.00
65.00	06500	RESPIRATORY THERAPY	-46,054	1,222,601		65.00
66.00	06600	PHYSICAL THERAPY	-50,128	1,525,973		66.00
66.01	06601	CLINICAL NUTRITION	0	180,463		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	137,717		67.00
68.00	06800	SPEECH PATHOLOGY	0	106,315		68.00
69.00	06900	ELECTROCARDIOLOGY	-490,724	935,744		69.00
69.01	06901	CARDIAC REHABILITATION	-10,864	76,254		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	-268,317	132,834		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	-44,126	3,096,434		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	739,048		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,598,477		73.00
74.00	07400	RENAL DIALYSIS	0	129,707		74.00
76.00	03330	ENDOSCOPY	-60,050	386,406		76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	37,709	1,851,662		90.00
91.00	09100	EMERGENCY	-1,301,635	2,315,360		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OPT	0	0		99.20
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,701,254	81,842,411		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	35,150		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-49,733		192.00
194.00	07950	NONREIMBURSABLE	0	273,609		194.00
194.01	07951	RETAIL PHARMACY	0	122,089		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-16,701,254	82,223,526		200.00

RECLASSIFICATIONS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/18/2018 12:29 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS FROM OB TO NURSERY				
1.00	NURSERY	43.00	110,663	0	1.00
2.00	NURSERY	43.00	0	15,530	2.00
	0		110,663	15,530	
	B - RECLASS FROM OB TO DELIVERY ROOM				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	781,289	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	109,641	2.00
	0		781,289	109,641	
	C - RECLASS FROM DIETARY TO CAFETERIA				
1.00	CAFETERIA	11.00	555,211	0	1.00
2.00	CAFETERIA	11.00	0	450,353	2.00
	0		555,211	450,353	
	D - IV PUMP COST				
1.00	ADULTS & PEDIATRICS	30.00	0	16,294	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	488	2.00
3.00	INTRAVENOUS THERAPY	64.00	0	7,254	3.00
4.00	CLINIC	90.00	0	3	4.00
5.00	EMERGENCY	91.00	0	5,844	5.00
	TOTALS		0	29,883	
	E - MAIL ROOM				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,729	1.00
	TOTALS		0	4,729	
	G - CENTRAL SERVICES RECLASS				
1.00	ADULTS & PEDIATRICS	30.00	45	0	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	11	2.00
3.00	OPERATING ROOM	50.00	37,817	0	3.00
4.00	OPERATING ROOM	50.00	0	8,896	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	485	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	114	6.00
7.00	CT SCAN	57.00	25	0	7.00
8.00	CT SCAN	57.00	0	6	8.00
9.00	CARDIAC CATHETERIZATION	59.00	22,719	0	9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	5,345	10.00
11.00	RESPIRATORY THERAPY	65.00	88,763	0	11.00
12.00	RESPIRATORY THERAPY	65.00	0	20,881	12.00
13.00	PHYSICAL THERAPY	66.00	2,661	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	626	14.00
15.00	OCCUPATIONAL THERAPY	67.00	44	0	15.00
16.00	OCCUPATIONAL THERAPY	67.00	0	10	16.00
17.00	SPEECH PATHOLOGY	68.00	262	0	17.00
18.00	SPEECH PATHOLOGY	68.00	0	62	18.00
19.00	ENDOSCOPY	76.00	49	0	19.00
20.00	ENDOSCOPY	76.00	0	11	20.00
21.00	CLINIC	90.00	548	0	21.00
22.00	CLINIC	90.00	0	129	22.00
	TOTALS		153,418	36,091	
	J - RECLASS O/S PRINTING TO NON-REIMBURS				
1.00	NONREIMBURSABLE	194.00	29,061	0	1.00
2.00	NONREIMBURSABLE	194.00	0	35,950	2.00
	0		29,061	35,950	
	L - RECLASS UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	214,619	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
	0		0	214,619	
	M - RECLASS REAL ESTATE TAXES				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	119,436	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	119,436	
	O - BUILDING INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	110,973	1.00
	TOTALS		0	110,973	
	P - C. SUPPLIES - CHARGEABLE IMPLANTABLE				
1.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	739,048	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

RECLASSIFICATIONS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/18/2018 12:29 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	0		0	739,048		
	Q - C. SUPPLIES-CHARGEABLE MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PAT	71.00	0	3,140,560		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
	0		0	3,140,560		
	R - PHARM-DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,598,477		1.00
	0		0	3,598,477		
500.00	Grand Total: Increases		1,629,642	8,605,290		500.00

RECLASSIFICATIONS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/18/2018 12:29 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS FROM OB TO NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	110,663	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	15,530	0		2.00
	0		110,663	15,530			
	B - RECLASS FROM OB TO DELIVERY ROOM						
1.00	ADULTS & PEDIATRICS	30.00	781,289	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	109,641	0		2.00
	0		781,289	109,641			
	C - RECLASS FROM DIETARY TO CAFETERIA						
1.00	DIETARY	10.00	555,211	0	0		1.00
2.00	DIETARY	10.00	0	450,353	0		2.00
	0		555,211	450,353			
	D - IV PUMP COST						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	29,883	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	29,883			
	E - MAIL ROOM						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	4,729	0		1.00
	TOTALS		0	4,729			
	G - CENTRAL SERVICES RECLASS						
1.00	CENTRAL SERVICE & SUPPLY	14.00	153,417	0	0		1.00
2.00	CENTRAL SERVICE & SUPPLY	14.00	0	36,092	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
	TOTALS		153,417	36,092			
	J - RECLASS O/S PRINTING TO NON-REIMBURS						
1.00	ADMINISTRATIVE & GENERAL	5.00	29,061	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	35,950	0		2.00
	0		29,061	35,950			
	L - RECLASS UTILITIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,159	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	0	7,274	0		2.00
3.00	HOUSEKEEPING	9.00	0	101,307	0		3.00
4.00	SOCIAL SERVICE	17.00	0	434	0		4.00
5.00	OPERATING ROOM	50.00	0	198	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	10,336	0		6.00
7.00	CLINIC	90.00	0	4,211	0		7.00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	20,663	0		8.00
9.00	NONREIMBURSABLE	194.00	0	40,037	0		9.00
	0		0	214,619			
	M - RECLASS REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,056	13		1.00
2.00	NONREIMBURSABLE	194.00	0	3,996	13		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	111,384	13		3.00
	0		0	119,436			
	O - BUILDING INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	110,973	13		1.00
	TOTALS		0	110,973			
	P - C. SUPPLIES - CHARGEABLE IMPLANTABLE						
1.00	CENTRAL SERVICE & SUPPLY	14.00	0	6,970	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2	0		2.00
3.00	OPERATING ROOM	50.00	0	552,937	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	219	0		4.00

RECLASSIFICATIONS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/18/2018 12:29 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	120	0		5.00
6.00	CARDIAC CATHETERIZATION	59.00	0	115,083	0		6.00
7.00	INTRAVENOUS THERAPY	64.00	0	626	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	182	0		8.00
9.00	OCCUPATIONAL THERAPY	67.00	0	18	0		9.00
10.00	ENDOSCOPY	76.00	0	3,154	0		10.00
11.00	CLINIC	90.00	0	59,737	0		11.00
	0		0	739,048			
	Q - C. SUPPLIES-CHARGEABLE MED SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	542,306	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	191,256	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	8,628	0		3.00
4.00	OPERATING ROOM	50.00	0	1,419,884	0		4.00
5.00	RECOVERY ROOM	51.00	0	7,419	0		5.00
6.00	ANESTHESIOLOGY	53.00	0	110,119	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,946	0		7.00
8.00	RADIOLOGY - THERAPEUTIC	55.00	0	2,106	0		8.00
9.00	RADIOISOTOPE	56.00	0	3,070	0		9.00
10.00	CT SCAN	57.00	0	45,415	0		10.00
11.00	MRI	58.00	0	30,633	0		11.00
12.00	CARDIAC CATHETERIZATION	59.00	0	45,637	0		12.00
13.00	LABORATORY	60.00	0	64,459	0		13.00
14.00	INTRAVENOUS THERAPY	64.00	0	50,362	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	43,271	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	11,174	0		16.00
17.00	OCCUPATIONAL THERAPY	67.00	0	1,414	0		17.00
18.00	SPEECH PATHOLOGY	68.00	0	16	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	17,524	0		19.00
20.00	CARDIAC REHABILITATION	69.01	0	419	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,678	0		21.00
22.00	RENAL DIALYSIS	74.00	0	1,114	0		22.00
23.00	ENDOSCOPY	76.00	0	107,518	0		23.00
24.00	CLINIC	90.00	0	32,855	0		24.00
25.00	EMERGENCY	91.00	0	355,728	0		25.00
26.00	GIFT FLOWER COFFEE SHOP & CAN	190.00	0	4	0		26.00
27.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	593	0		27.00
28.00	NONREIMBURSABLE	194.00	0	12	0		28.00
	0		0	3,140,560			
	R - PHARM-DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	3,598,477	0		1.00
	0		0	3,598,477			
500.00	Grand Total: Decreases		1,629,641	8,605,291			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,259,000	0	0	0	0	1.00
2.00	Land Improvements	667,527	0	0	0	0	2.00
3.00	Buildings and Fixtures	30,421,759	4,843,646	0	4,843,646	48,774	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,324,495	1,045,796	0	1,045,796	0	5.00
6.00	Movable Equipment	22,193,890	1,407,673	0	1,407,673	201,984	6.00
7.00	HIT designated Assets	1,885,308	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,751,979	7,297,115	0	7,297,115	250,758	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	59,751,979	7,297,115	0	7,297,115	250,758	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,259,000	0	1.00
2.00	Land Improvements	667,527	0	2.00
3.00	Buildings and Fixtures	35,216,631	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,370,291	0	5.00
6.00	Movable Equipment	23,399,579	0	6.00
7.00	HIT designated Assets	1,885,308	0	7.00
8.00	Subtotal (sum of lines 1-7)	66,798,336	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	66,798,336	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/18/2018 12:29 pm

	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	1,833,247	0	2,312,166	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,105,111	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,938,358	0	2,312,166	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	4,145,413	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,105,111	2.00
3.00	Total (sum of lines 1-2)	0	6,250,524	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/18/2018 12:29 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	43,192,459	0	43,192,459	0.646610	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,605,877	0	23,605,877	0.353390	0	2.00
3.00	Total (sum of lines 1-2)	66,798,336	0	66,798,336	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,117,833	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,559,567	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,677,400	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,312,166	0	230,409	0	4,660,408	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	2,559,567	2.00
3.00	Total (sum of lines 1-2)	2,312,166	0	230,409	0	7,219,975	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/18/2018 12:29 pm

	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)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-360,582	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	0	ADMINISTRATIVE & GENERAL	5.00	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	-6,460,103			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	-9,456,635			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-97,610	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	A	-1,172	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	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	A	179,244	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	35,623	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist	A	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/18/2018 12:29 pm

	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
34.00	MISC. REVENUE	B	-26,394	OPERATION OF PLANT	7.00	0	34.00
35.02	MISC. REVENUE	B	-154	HOUSEKEEPING	9.00	0	35.02
39.00	MISC. REVENUE	B	-80	CAFETERIA	11.00	0	39.00
40.00	MISC. REVENUE	B	-37,220	PHARMACY	15.00	0	40.00
41.01	MISC. REVENUE	B	-18	ADULTS & PEDIATRICS	30.00	0	41.01
42.00	MISC. REVENUE	B	-36,000	RADIOLOGY - THERAPEUTIC	55.00	0	42.00
44.00	MISC. REVENUE	B	18	LABORATORY	60.00	0	44.00
44.01	MISC. REVENUE	B	-2,667	RESPIRATORY THERAPY	65.00	0	44.01
44.02	MISC.REVENUE	B	-10,864	CARDIAC REHABILITATION	69.01	0	44.02
44.03	GIFTS CONTRIBUTIONS & ENTERTAIMENT	A	14,368	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.03
45.00	GIFTS CONTRIBUTIONS & ENTERTAIMENT	A	-34,234	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	GIFTS CONTRIBUTIONS & ENTERTAI	A	-118	DIETARY	10.00	0	45.01
45.02	GIFTS CONTRIBUTIONS & ENTERTAI	A	-4,577	NURSING ADMINISTRATION	13.00	0	45.02
45.03	GIFTS CONTRIBUTIONS & ENTERTAI	A	-2,511	ADULTS & PEDIATRICS	30.00	0	45.03
45.04	GIFTS CONTRIBUTIONS & ENTERTAINMENT	A	-125	INTENSIVE CARE UNIT	31.00	0	45.04
45.05	GIFTS CONTRIBUTIONS & ENTERTAI	A	-382	SUBPROVIDER - IPF	40.00	0	45.05
45.06	GIFTS CONTRIBUTIONS & ENTERTAI	A	-90	OPERATING ROOM	50.00	0	45.06
45.07	GIFTS CONTRIBUTIONS & ENTERTAI	A	-327	LABORATORY	60.00	0	45.07
45.08	GIFTS CONTRIBUTIONS & ENTERTAI	A	-42	INTRAVENOUS THERAPY	64.00	0	45.08
45.09	GIFTS CONTRIBUTIONS & ENTERTAI	A	-70	ELECTROCARDIOLOGY	69.00	0	45.09
45.10	GIFTS CONTRIBUTIONS & ENTERTAI	A	-61	CLINIC	90.00	0	45.10
45.11	GIFTS CONTRIBUTIONS & ENTERTAI	A	-474	EMERGENCY	91.00	0	45.11
45.12	AMORTIZATION OF GOODWILL	A	-140,151	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.12
45.13	PATIENT TELEPHONE SERVICES	A	-25	CAP REL COSTS-BLDG & FIXT	1.00	9	45.13
45.15	PATIENT TELEPHONE SERVICE	A	-12,997	ADMINISTRATIVE & GENERAL	5.00	0	45.15
45.16	PATIENT TELEPHONE SERVICE	A	-16,668	ADMINISTRATIVE & GENERAL	5.00	0	45.16
45.17	PATIENT TELEPHONE SERVICE	A	-37	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.17
45.18	PERSONAL USE (AUTO)		0		0.00	9	45.18
45.21	GIFTS CONTRIBUTIONS & ENTERTAI		0	EMERGENCY	91.00	0	45.21
45.25	PHYSICIAN RECRUITMENT		0	ADMINISTRATIVE & GENERAL	5.00	0	45.25
45.27	GIFTS CONTRIBUTIONS & ENTERTAI		0	CLINIC	90.00	0	45.27
45.29	PATIENT TELEPHONE SERVICE		0		0.00	0	45.29
45.30	PATIENT TELEPHONE SERVICE BENEF	A	-5,110	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.30
45.31	MEDICAL RECORDS BENEFITS		0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.31
45.32	PROF LIAB INS DEDUCTIBLE RESERV	A	-169,346	ADMINISTRATIVE & GENERAL	5.00	0	45.32
45.40	WSI RENT EXPENSE	A	-49,593	PHYSICAL THERAPY	66.00	0	45.40
45.46	DUES RELATED TO LOBBYING EXP.	A	-4,070	ADMINISTRATIVE & GENERAL	5.00	0	45.46
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-16,701,254				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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/18/2018 12:29 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	105,367	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	559,021	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFIT DEPARTMENT	7,102,014	11,929,962	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	6,554,389	11,290,338	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	0	513,000	4.01
4.02	71.00	MEDICAL SUPPLIES CHARGED TO	HOME OFFICE	-44,126	0	4.02
4.03	0.00			0	0	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			14,276,665	23,733,300	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	SSM HEALTH CARE	100.00	MOTHERHOUSE	100.00	6.00
7.00	B	SSM HEALTH STL	100.00	SSM	100.00	7.00
8.00	B	SSM HEALTH	100.00	FSI	100.00	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: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/18/2018 12:29 pm

	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	105,367	9		1.00
2.00	559,021	9		2.00
3.00	-4,827,948	11		3.00
4.00	-4,735,949	0		4.00
4.01	-513,000	0		4.01
4.02	-44,126	0		4.02
4.03	0	0		4.03
5.00	-9,456,635			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	CONVENT		6.00
7.00	CORPORATE		7.00
8.00	CORPORATE		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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/18/2018 12:29 pm

	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	5.00	ADMINISTRATIVE & GENERAL	139,203	-9,121	148,324	159,800	1,075	1.00
2.00	30.00	ADULTS & PEDIATRICS	723,824	723,824	0	159,800	0	2.00
3.00	50.00	OPERATING ROOM	3,000	3,000	0	182,900	0	3.00
4.00	53.00	ANESTHESIOLOGY	2,602,598	2,602,598	0	167,500	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	924,303	924,303	0	217,600	0	5.00
6.00	56.00	RADIOISOTOPE	23,430	23,430	0	217,600	0	6.00
7.00	60.00	LABORATORY	387,453	0	387,453	208,000	3,875	7.00
8.00	65.00	RESPIRATORY THERAPY	51,223	41,023	10,200	159,800	102	8.00
9.00	66.00	PHYSICAL THERAPY	535	535	0	159,800	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	490,654	490,654	0	159,800	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	276,153	265,953	10,200	159,800	102	11.00
12.00	76.00	ENDOSCOPY	60,434	13,923	46,511	159,800	5	12.00
13.00	90.00	CLINIC	-37,770	-37,770	0	159,800	0	13.00
14.00	91.00	EMERGENCY	1,301,161	1,301,161	0	159,800	0	14.00
200.00			6,946,201	6,343,513	602,688		5,159	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	5.00	ADMINISTRATIVE & GENERAL	82,589	4,129	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	387,500	19,375	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	7,836	392	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	7,836	392	0	0	0	11.00
12.00	76.00	ENDOSCOPY	384	19	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
14.00	91.00	EMERGENCY	0	0	0	0	0	14.00
200.00			486,145	24,307	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	5.00	ADMINISTRATIVE & GENERAL	0	82,589	65,735	56,614		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	723,824		2.00
3.00	50.00	OPERATING ROOM	0	0	0	3,000		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	2,602,598		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	924,303		5.00
6.00	56.00	RADIOISOTOPE	0	0	0	23,430		6.00
7.00	60.00	LABORATORY	0	387,500	0	0		7.00
8.00	65.00	RESPIRATORY THERAPY	0	7,836	2,364	43,387		8.00
9.00	66.00	PHYSICAL THERAPY	0	0	0	535		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	0	0	490,654		10.00
11.00	70.00	ELECTROENCEPHALOGRAPHY	0	7,836	2,364	268,317		11.00
12.00	76.00	ENDOSCOPY	0	384	46,127	60,050		12.00
13.00	90.00	CLINIC	0	0	0	-37,770		13.00
14.00	91.00	EMERGENCY	0	0	0	1,301,161		14.00
200.00			0	486,145	116,590	6,460,103		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,660,408	4,660,408				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,559,567		2,559,567			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,804,802	25,447	532	8,830,781		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,540,660	1,461,476	213,162	818,727	17,034,025	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	5,086,167	352,442	1,024,355	195,832	6,658,796	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	441,023	94,244	1,233	30,210	566,710	8.00
9.00	00900	HOUSEKEEPING	1,172,772	60,601	3,813	264,538	1,501,724	9.00
10.00	01000	DIETARY	361,756	34,491	4,028	66,392	466,667	10.00
11.00	01100	CAFETERIA	1,005,484	88,428	8,815	145,297	1,248,024	11.00
13.00	01300	NURSING ADMINISTRATION	893,663	8,696	129,527	207,517	1,239,403	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	260,145	0	0	23,224	283,369	14.00
15.00	01500	PHARMACY	1,401,610	0	2,592	316,210	1,720,412	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	727,551	52,557	1,528	140,171	921,807	16.00
17.00	01700	SOCIAL SERVICE	1,028,608	21,621	0	196,630	1,246,859	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,054,785	595,193	111,140	1,753,241	8,514,359	30.00
31.00	03100	INTENSIVE CARE UNIT	2,404,561	63,036	79,803	464,920	3,012,320	31.00
40.00	04000	SUBPROVIDER - IPF	2,043,626	77,873	18,362	515,304	2,655,165	40.00
43.00	04300	NURSERY	126,193	42,285	116	0	168,594	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,750,559	496,753	210,957	481,245	3,939,514	50.00
51.00	05100	RECOVERY ROOM	344,559	0	0	87,153	431,712	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	890,930	71,764	195	0	962,889	52.00
53.00	05300	ANESTHESIOLOGY	330,479	4,522	9,618	57,294	401,913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,057,801	152,073	130,279	264,075	1,604,228	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	636,081	0	149,122	126,279	911,482	55.00
56.00	05600	RADIOISOTOPE	605,357	10,261	11,821	44,154	671,593	56.00
57.00	05700	CT SCAN	356,163	7,620	25,570	86,177	475,530	57.00
58.00	05800	MRI	164,573	4,435	5,363	40,001	214,372	58.00
59.00	05900	CARDIAC CATHETERIZATION	214,108	27,838	22,618	51,580	316,144	59.00
60.00	06000	LABORATORY	4,224,534	77,156	33,094	441,385	4,776,169	60.00
64.00	06400	INTRAVENOUS THERAPY	258,891	11,533	198	61,155	331,777	64.00
65.00	06500	RESPIRATORY THERAPY	1,222,601	13,599	15,462	278,206	1,529,868	65.00
66.00	06600	PHYSICAL THERAPY	1,525,973	51,753	5,793	315,591	1,899,110	66.00
66.01	06601	CLINICAL NUTRITION	180,463	0	0	46,879	227,342	66.01
67.00	06700	OCCUPATIONAL THERAPY	137,717	0	2	35,846	173,565	67.00
68.00	06800	SPEECH PATHOLOGY	106,315	7,859	61	26,555	140,790	68.00
69.00	06900	ELECTROCARDIOLOGY	935,744	65,210	64,460	180,761	1,246,175	69.00
69.01	06901	CARDIAC REHABILITATION	76,254	0	424	22,532	99,210	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	132,834	23,969	2,548	31,278	190,629	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,096,434	0	0	0	3,096,434	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	739,048	0	0	0	739,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,598,477	0	0	0	3,598,477	73.00
74.00	07400	RENAL DIALYSIS	129,707	0	0	0	129,707	74.00
76.00	03330	ENDOSCOPY	386,406	0	2,875	100,164	489,445	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,851,662	119,995	32,088	334,046	2,337,791	90.00
91.00	09100	EMERGENCY	2,315,360	64,655	24,754	553,538	2,958,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	81,842,411	4,189,385	2,346,308	8,804,107	81,131,455	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	35,150	3,565	0	8,635	47,350	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-49,733	0	202,233	0	152,500	192.00
194.00	07950	NONREIMBURSABLE	273,609	467,458	11,026	18,039	770,132	194.00
194.01	07951	RETAIL PHARMACY	122,089	0	0	0	122,089	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	82,223,526	4,660,408	2,559,567	8,830,781	82,223,526	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		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	17,034,025					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,739,943	0	8,398,739			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	148,081	0	280,580	995,371		8.00
9.00	00900	HOUSEKEEPING	392,400	0	180,419	130,370	2,204,913	9.00
10.00	01000	DIETARY	121,940	0	102,685	4,670	985	10.00
11.00	01100	CAFETERIA	326,109	0	263,267	10,222	1,970	11.00
13.00	01300	NURSING ADMINISTRATION	323,856	0	25,890	0	3,283	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	74,044	0	0	0	0	14.00
15.00	01500	PHARMACY	449,544	0	0	0	21,337	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,868	0	156,471	0	10,176	16.00
17.00	01700	SOCIAL SERVICE	325,804	0	64,368	0	11,161	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,224,813	0	1,771,994	313,156	585,611	30.00
31.00	03100	INTENSIVE CARE UNIT	787,119	0	187,668	54,570	137,540	31.00
40.00	04000	SUBPROVIDER - IPF	693,795	0	231,843	46,719	111,280	40.00
43.00	04300	NURSERY	44,054	0	125,889	4,081	14,772	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,029,395	0	1,478,921	94,677	250,461	50.00
51.00	05100	RECOVERY ROOM	112,806	0	0	0	16,741	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	251,603	0	213,655	0	102,745	52.00
53.00	05300	ANESTHESIOLOGY	105,020	0	13,463	0	11,161	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	419,185	0	452,747	83,181	12,146	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	238,170	0	0	6,860	7,222	55.00
56.00	05600	RADIOISOTOPE	175,487	0	30,550	0	3,939	56.00
57.00	05700	CT SCAN	124,256	0	22,686	0	7,222	57.00
58.00	05800	MRI	56,015	0	13,204	0	4,596	58.00
59.00	05900	CARDIAC CATHETERIZATION	82,608	0	82,880	2,686	24,291	59.00
60.00	06000	LABORATORY	1,248,013	0	229,707	69	59,415	60.00
64.00	06400	INTRAVENOUS THERAPY	86,693	0	34,336	4,437	19,696	64.00
65.00	06500	RESPIRATORY THERAPY	399,755	0	40,485	0	19,696	65.00
66.00	06600	PHYSICAL THERAPY	496,237	0	154,077	49,707	100,775	66.00
66.01	06601	CLINICAL NUTRITION	59,404	0	0	0	2,626	66.01
67.00	06700	OCCUPATIONAL THERAPY	45,353	0	0	0	9,519	67.00
68.00	06800	SPEECH PATHOLOGY	36,788	0	23,398	0	6,237	68.00
69.00	06900	ELECTROCARDIOLOGY	325,626	0	194,141	16,084	26,589	69.00
69.01	06901	CARDIAC REHABILITATION	25,924	0	0	0	6,565	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	49,811	0	71,359	8,408	5,580	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	809,098	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	193,113	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	940,282	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	33,892	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	127,892	0	0	0	21,993	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	610,865	0	357,246	5,210	247,507	90.00
91.00	09100	EMERGENCY	773,006	0	192,490	144,570	179,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,748,667	0	6,996,419	979,677	2,044,723	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	12,373	0	10,615	0	2,298	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,848	0	0	15,694	129,334	192.00
194.00	07950	NONREIMBURSABLE	201,235	0	1,391,705	0	28,558	194.00
194.01	07951	RETAIL PHARMACY	31,902	0	0	0	0	194.01
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)	17,034,025	0	8,398,739	995,371	2,204,913	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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	696,947					10.00
11.00	01100	CAFETERIA	0	1,849,592				11.00
13.00	01300	NURSING ADMINISTRATION	0	41,269	1,633,701			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	7,503	6,703	371,619		14.00
15.00	01500	PHARMACY	0	56,276	51,488	1,099	2,300,156	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	48,772	44,637	11	0	16.00
17.00	01700	SOCIAL SERVICE	0	41,269	38,647	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	454,924	480,221	430,942	47,865	0	30.00
31.00	03100	INTENSIVE CARE UNIT	37,812	101,296	90,106	17,080	0	31.00
40.00	04000	SUBPROVIDER - IPF	136,729	135,061	120,355	1,362	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,819	135,061	120,580	194,829	0	50.00
51.00	05100	RECOVERY ROOM	0	18,759	15,296	1,369	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,752	4,078	10,460	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,531	61,217	4,015	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	9,659	26,262	23,120	336	0	55.00
56.00	05600	RADIOISOTOPE	0	7,503	7,763	221	0	56.00
57.00	05700	CT SCAN	0	22,510	18,685	3,685	0	57.00
58.00	05800	MRI	0	7,503	8,307	2,803	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,595	11,255	10,039	14,276	0	59.00
60.00	06000	LABORATORY	0	135,061	121,720	5,011	0	60.00
64.00	06400	INTRAVENOUS THERAPY	2,483	15,007	13,798	4,701	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	82,538	74,579	4,961	0	65.00
66.00	06600	PHYSICAL THERAPY	0	67,531	61,537	1,087	0	66.00
66.01	06601	CLINICAL NUTRITION	0	15,007	12,344	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	7,503	5,893	41	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,503	5,525	80	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,155	45,020	40,480	1,560	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	7,503	5,103	84	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,944	7,503	7,469	204	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,300,156	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	235	0	74.00
76.00	03330	ENDOSCOPY	9,596	22,510	19,556	11,536	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	965	93,793	82,805	8,672	0	90.00
91.00	09100	EMERGENCY	33,266	131,310	117,425	34,034	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	696,947	1,849,592	1,620,197	371,617	2,300,156	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	3,504	1	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1	0	192.00
194.00	07950	NONREIMBURSABLE	0	0	10,000	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	696,947	1,849,592	1,633,701	371,619	2,300,156	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/18/2018 12:29 pm

		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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,422,742					16.00
17.00	01700	SOCIAL SERVICE	0	1,728,108				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	99,592	1,140,551	16,064,028	0	16,064,028	30.00
31.00	03100	INTENSIVE CARE UNIT	14,227	172,811	4,612,549	0	4,612,549	31.00
40.00	04000	SUBPROVIDER - IPF	14,227	414,746	4,561,282	0	4,561,282	40.00
43.00	04300	NURSERY	0	0	357,390	0	357,390	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	142,274	0	7,388,531	0	7,388,531	50.00
51.00	05100	RECOVERY ROOM	14,227	0	610,910	0	610,910	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,227	0	1,545,119	0	1,545,119	52.00
53.00	05300	ANESTHESIOLOGY	28,455	0	578,302	0	578,302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,137	0	2,775,387	0	2,775,387	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,455	0	1,251,566	0	1,251,566	55.00
56.00	05600	RADIOISOTOPE	42,682	0	939,738	0	939,738	56.00
57.00	05700	CT SCAN	142,274	0	816,848	0	816,848	57.00
58.00	05800	MRI	28,455	0	335,255	0	335,255	58.00
59.00	05900	CARDIAC CATHETERIZATION	14,227	0	561,001	0	561,001	59.00
60.00	06000	LABORATORY	270,324	0	6,845,489	0	6,845,489	60.00
64.00	06400	INTRAVENOUS THERAPY	14,227	0	527,155	0	527,155	64.00
65.00	06500	RESPIRATORY THERAPY	56,910	0	2,208,792	0	2,208,792	65.00
66.00	06600	PHYSICAL THERAPY	28,455	0	2,858,516	0	2,858,516	66.00
66.01	06601	CLINICAL NUTRITION	0	0	316,723	0	316,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	241,874	0	241,874	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	220,321	0	220,321	68.00
69.00	06900	ELECTROCARDIOLOGY	71,137	0	1,970,967	0	1,970,967	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	144,389	0	144,389	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	342,907	0	342,907	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	14,227	0	3,919,759	0	3,919,759	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	14,227	0	946,388	0	946,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,047	0	6,966,962	0	6,966,962	73.00
74.00	07400	RENAL DIALYSIS	0	0	163,834	0	163,834	74.00
76.00	03330	ENDOSCOPY	28,455	0	730,983	0	730,983	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	28,455	0	3,773,309	0	3,773,309	90.00
91.00	09100	EMERGENCY	113,819	0	4,678,113	0	4,678,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,422,742	1,728,108	79,254,387	0	79,254,387	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	76,141	0	76,141	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	337,377	0	337,377	192.00
194.00	07950	NONREIMBURSABLE	0	0	2,401,630	0	2,401,630	194.00
194.01	07951	RETAIL PHARMACY	0	0	153,991	0	153,991	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,422,742	1,728,108	82,223,526	0	82,223,526	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/18/2018 12:29 pm

		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	0	25,447	532	25,979	25,979	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	647,472	1,461,476	213,162	2,322,110	2,409	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	-1,713	352,442	1,024,355	1,375,084	576	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-2	94,244	1,233	95,475	89	8.00
9.00	00900	HOUSEKEEPING	38,123	60,601	3,813	102,537	778	9.00
10.00	01000	DIETARY	0	34,491	4,028	38,519	195	10.00
11.00	01100	CAFETERIA	0	88,428	8,815	97,243	428	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,696	129,527	138,223	611	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	1,729	0	0	1,729	68	14.00
15.00	01500	PHARMACY	0	0	2,592	2,592	930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	52,557	1,528	54,085	412	16.00
17.00	01700	SOCIAL SERVICE	0	21,621	0	21,621	579	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,525	595,193	111,140	760,858	5,153	30.00
31.00	03100	INTENSIVE CARE UNIT	1,000	63,036	79,803	143,839	1,368	31.00
40.00	04000	SUBPROVIDER - IPF	0	77,873	18,362	96,235	1,516	40.00
43.00	04300	NURSERY	0	42,285	116	42,401	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,457	496,753	210,957	715,167	1,416	50.00
51.00	05100	RECOVERY ROOM	2,464	0	0	2,464	256	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	71,764	195	71,959	0	52.00
53.00	05300	ANESTHESIOLOGY	1,096	4,522	9,618	15,236	169	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	152,073	130,279	282,352	777	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	149,122	149,122	372	55.00
56.00	05600	RADIOISOTOPE	0	10,261	11,821	22,082	130	56.00
57.00	05700	CT SCAN	0	7,620	25,570	33,190	254	57.00
58.00	05800	MRI	8,441	4,435	5,363	18,239	118	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	27,838	22,618	50,456	152	59.00
60.00	06000	LABORATORY	105	77,156	33,094	110,355	1,299	60.00
64.00	06400	INTRAVENOUS THERAPY	0	11,533	198	11,731	180	64.00
65.00	06500	RESPIRATORY THERAPY	23,441	13,599	15,462	52,502	819	65.00
66.00	06600	PHYSICAL THERAPY	78,089	51,753	5,793	135,635	929	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	0	138	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	2	2	105	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,859	61	7,920	78	68.00
69.00	06900	ELECTROCARDIOLOGY	14,941	65,210	64,460	144,611	532	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	424	424	66	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	23,969	2,548	26,517	92	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	105	0	2,875	2,980	295	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	40,859	119,995	32,088	192,942	983	90.00
91.00	09100	EMERGENCY	0	64,655	24,754	89,409	1,629	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	918,132	4,189,385	2,346,308	7,453,825	25,901	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	3,565	0	3,565	25	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	54,147	0	202,233	256,380	0	192.00
194.00	07950	NONREIMBURSABLE	15,564	467,458	11,026	494,048	53	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	987,843	4,660,408	2,559,567	8,207,818	25,979	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/18/2018 12:29 pm

		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	2,324,519					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	237,439	0	1,613,099			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,208	0	53,890	169,662		8.00
9.00	00900	HOUSEKEEPING	53,548	0	34,652	22,222	213,737	9.00
10.00	01000	DIETARY	16,640	0	19,722	796	95	10.00
11.00	01100	CAFETERIA	44,502	0	50,564	1,742	191	11.00
13.00	01300	NURSING ADMINISTRATION	44,195	0	4,973	0	318	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	10,104	0	0	0	0	14.00
15.00	01500	PHARMACY	61,346	0	0	0	2,068	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	32,870	0	30,053	0	986	16.00
17.00	01700	SOCIAL SERVICE	44,460	0	12,363	0	1,082	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	303,599	0	340,333	53,377	56,768	30.00
31.00	03100	INTENSIVE CARE UNIT	107,413	0	36,044	9,302	13,333	31.00
40.00	04000	SUBPROVIDER - IPF	94,678	0	44,529	7,963	10,787	40.00
43.00	04300	NURSERY	6,012	0	24,179	696	1,432	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,475	0	284,048	16,138	24,279	50.00
51.00	05100	RECOVERY ROOM	15,394	0	0	0	1,623	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	34,335	0	41,036	0	9,960	52.00
53.00	05300	ANESTHESIOLOGY	14,331	0	2,586	0	1,082	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,204	0	86,957	14,178	1,177	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	32,502	0	0	1,169	700	55.00
56.00	05600	RADIOISOTOPE	23,948	0	5,868	0	382	56.00
57.00	05700	CT SCAN	16,956	0	4,357	0	700	57.00
58.00	05800	MRI	7,644	0	2,536	0	445	58.00
59.00	05900	CARDIAC CATHETERIZATION	11,273	0	15,918	458	2,355	59.00
60.00	06000	LABORATORY	170,309	0	44,119	12	5,759	60.00
64.00	06400	INTRAVENOUS THERAPY	11,831	0	6,595	756	1,909	64.00
65.00	06500	RESPIRATORY THERAPY	54,552	0	7,776	0	1,909	65.00
66.00	06600	PHYSICAL THERAPY	67,718	0	29,593	8,473	9,769	66.00
66.01	06601	CLINICAL NUTRITION	8,107	0	0	0	255	66.01
67.00	06700	OCCUPATIONAL THERAPY	6,189	0	0	0	923	67.00
68.00	06800	SPEECH PATHOLOGY	5,020	0	4,494	0	605	68.00
69.00	06900	ELECTROCARDIOLOGY	44,436	0	37,288	2,742	2,577	69.00
69.01	06901	CARDIAC REHABILITATION	3,538	0	0	0	636	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,797	0	13,705	1,433	541	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	110,413	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	26,353	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,314	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,625	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	17,453	0	0	0	2,132	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	83,361	0	68,614	888	23,993	90.00
91.00	09100	EMERGENCY	105,487	0	36,971	24,642	17,438	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,285,579	0	1,343,763	166,987	198,209	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	1,688	0	2,039	0	223	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,438	0	0	2,675	12,537	192.00
194.00	07950	NONREIMBURSABLE	27,461	0	267,297	0	2,768	194.00
194.01	07951	RETAIL PHARMACY	4,353	0	0	0	0	194.01
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)	2,324,519	0	1,613,099	169,662	213,737	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICE & 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	75,967					10.00
11.00	01100	CAFETERIA	0	194,670				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,344	192,664			13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	790	791	13,482		14.00
15.00	01500	PHARMACY	0	5,923	6,072	40	78,971	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,133	5,264	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	4,344	4,558	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,586	50,543	50,820	1,737	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,122	10,661	10,626	620	0	31.00
40.00	04000	SUBPROVIDER - IPF	14,903	14,215	14,194	49	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	307	14,215	14,220	7,065	0	50.00
51.00	05100	RECOVERY ROOM	0	1,974	1,804	50	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	395	481	380	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,108	7,219	146	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,053	2,764	2,727	12	0	55.00
56.00	05600	RADIOISOTOPE	0	790	915	8	0	56.00
57.00	05700	CT SCAN	0	2,369	2,204	134	0	57.00
58.00	05800	MRI	0	790	980	102	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	283	1,185	1,184	518	0	59.00
60.00	06000	LABORATORY	0	14,215	14,355	182	0	60.00
64.00	06400	INTRAVENOUS THERAPY	271	1,579	1,627	171	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	8,687	8,795	180	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,108	7,257	39	0	66.00
66.01	06601	CLINICAL NUTRITION	0	1,579	1,456	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	790	695	1	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	790	652	3	0	68.00
69.00	06900	ELECTROCARDIOLOGY	453	4,738	4,774	57	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	790	602	3	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	212	790	881	7	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	78,971	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	9	0	74.00
76.00	03330	ENDOSCOPY	1,046	2,369	2,306	419	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	105	9,872	9,765	315	0	90.00
91.00	09100	EMERGENCY	3,626	13,820	13,848	1,235	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	75,967	194,670	191,072	13,482	78,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	413	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	NONREIMBURSABLE	0	0	1,179	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
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)	75,967	194,670	192,664	13,482	78,971	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/18/2018 12:29 pm

		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 SERVICE & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,803					16.00
17.00	01700	SOCIAL SERVICE	0	89,007				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,016	58,744	1,740,534	0	1,740,534	30.00
31.00	03100	INTENSIVE CARE UNIT	1,288	8,901	347,517	0	347,517	31.00
40.00	04000	SUBPROVIDER - IPF	1,288	21,362	321,719	0	321,719	40.00
43.00	04300	NURSERY	0	0	74,720	0	74,720	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,880	0	1,230,210	0	1,230,210	50.00
51.00	05100	RECOVERY ROOM	1,288	0	24,853	0	24,853	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,288	0	158,578	0	158,578	52.00
53.00	05300	ANESTHESIOLOGY	2,576	0	37,236	0	37,236	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,440	0	463,558	0	463,558	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	2,576	0	192,997	0	192,997	55.00
56.00	05600	RADIOISOTOPE	3,864	0	57,987	0	57,987	56.00
57.00	05700	CT SCAN	12,880	0	73,044	0	73,044	57.00
58.00	05800	MRI	2,576	0	33,430	0	33,430	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,288	0	85,070	0	85,070	59.00
60.00	06000	LABORATORY	24,475	0	385,080	0	385,080	60.00
64.00	06400	INTRAVENOUS THERAPY	1,288	0	37,938	0	37,938	64.00
65.00	06500	RESPIRATORY THERAPY	5,152	0	140,372	0	140,372	65.00
66.00	06600	PHYSICAL THERAPY	2,576	0	269,097	0	269,097	66.00
66.01	06601	CLINICAL NUTRITION	0	0	11,535	0	11,535	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	8,705	0	8,705	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	19,562	0	19,562	68.00
69.00	06900	ELECTROCARDIOLOGY	6,440	0	248,648	0	248,648	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	6,059	0	6,059	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	50,975	0	50,975	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1,288	0	111,701	0	111,701	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,288	0	27,641	0	27,641	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,592	0	218,877	0	218,877	73.00
74.00	07400	RENAL DIALYSIS	0	0	4,634	0	4,634	74.00
76.00	03330	ENDOSCOPY	2,576	0	31,576	0	31,576	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,576	0	393,414	0	393,414	90.00
91.00	09100	EMERGENCY	10,304	0	318,409	0	318,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,803	89,007	7,125,676	0	7,125,676	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	0	7,953	0	7,953	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	277,030	0	277,030	192.00
194.00	07950	NONREIMBURSABLE	0	0	792,806	0	792,806	194.00
194.01	07951	RETAIL PHARMACY	0	0	4,353	0	4,353	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	128,803	89,007	8,207,818	0	8,207,818	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	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	428,736					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,957,587				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,341	822	33,744,247			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	134,449	329,590	3,128,530	-17,034,025	65,189,501	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	32,423	1,583,847	748,317	0	6,658,796	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,670	1,906	115,437	0	566,710	8.00
9.00	00900	HOUSEKEEPING	5,575	5,896	1,010,856	0	1,501,724	9.00
10.00	01000	DIETARY	3,173	6,228	253,699	0	466,667	10.00
11.00	01100	CAFETERIA	8,135	13,629	555,211	0	1,248,024	11.00
13.00	01300	NURSING ADMINISTRATION	800	200,274	792,965	0	1,239,403	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	0	0	88,742	0	283,369	14.00
15.00	01500	PHARMACY	0	4,007	1,208,304	0	1,720,412	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,835	2,363	535,624	0	921,807	16.00
17.00	01700	SOCIAL SERVICE	1,989	0	751,366	0	1,246,859	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	54,755	171,844	6,699,459	0	8,514,359	30.00
31.00	03100	INTENSIVE CARE UNIT	5,799	123,391	1,776,559	0	3,012,320	31.00
40.00	04000	SUBPROVIDER - IPF	7,164	28,391	1,969,086	0	2,655,165	40.00
43.00	04300	NURSERY	3,890	180	0	0	168,594	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,699	326,181	1,838,938	0	3,939,514	50.00
51.00	05100	RECOVERY ROOM	0	0	333,032	0	431,712	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,602	302	0	0	962,889	52.00
53.00	05300	ANESTHESIOLOGY	416	14,872	218,933	0	401,913	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,990	201,436	1,009,086	0	1,604,228	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	230,572	482,538	0	911,482	55.00
56.00	05600	RADIOISOTOPE	944	18,278	168,723	0	671,593	56.00
57.00	05700	CT SCAN	701	39,536	329,299	0	475,530	57.00
58.00	05800	MRI	408	8,292	152,853	0	214,372	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,561	34,972	197,097	0	316,144	59.00
60.00	06000	LABORATORY	7,098	51,170	1,686,628	0	4,776,169	60.00
64.00	06400	INTRAVENOUS THERAPY	1,061	306	233,687	0	331,777	64.00
65.00	06500	RESPIRATORY THERAPY	1,251	23,908	1,063,086	0	1,529,868	65.00
66.00	06600	PHYSICAL THERAPY	4,761	8,957	1,205,939	0	1,899,110	66.00
66.01	06601	CLINICAL NUTRITION	0	0	179,135	0	227,342	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	3	136,975	0	173,565	67.00
68.00	06800	SPEECH PATHOLOGY	723	94	101,473	0	140,790	68.00
69.00	06900	ELECTROCARDIOLOGY	5,999	99,668	690,728	0	1,246,175	69.00
69.01	06901	CARDIAC REHABILITATION	0	656	86,100	0	99,210	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,205	3,940	119,519	0	190,629	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	3,096,434	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	739,048	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,598,477	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	129,707	74.00
76.00	03330	ENDOSCOPY	0	4,446	382,747	0	489,445	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,039	49,615	1,276,460	0	2,337,791	90.00
91.00	09100	EMERGENCY	5,948	38,275	2,115,187	0	2,958,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	385,404	3,627,847	33,642,318	-17,034,025	64,097,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	328	0	32,998	0	47,350	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	312,691	0	0	152,500	192.00
194.00	07950	NONREIMBURSABLE	43,004	17,049	68,931	0	770,132	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	122,089	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,660,408	2,559,567	8,830,781		17,034,025	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.870111	0.646749	0.261697		0.261300	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			25,979		2,324,519	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000770		0.035658	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OFL AUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			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	3,469					6.00
7.00	00700	OPERATION OF PLANT	59	259,523				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,670	579,493			8.00
9.00	00900	HOUSEKEEPING	0	5,575	75,900	6,717		9.00
10.00	01000	DIETARY	0	3,173	2,719	3	99,642	10.00
11.00	01100	CAFETERIA	0	8,135	5,951	6	0	11.00
13.00	01300	NURSING ADMINISTRATION	57	800	0	10	0	13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	431	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	65	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,835	0	31	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,989	0	34	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	215	54,755	182,315	1,784	65,040	30.00
31.00	03100	INTENSIVE CARE UNIT	128	5,799	31,770	419	5,406	31.00
40.00	04000	SUBPROVIDER - IPF	10	7,164	27,199	339	19,548	40.00
43.00	04300	NURSERY	10	3,890	2,376	45	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	613	45,699	55,120	763	403	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71	6,602	0	313	0	52.00
53.00	05300	ANESTHESIOLOGY	172	416	0	34	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	404	13,990	48,427	37	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	13	0	3,994	22	1,381	55.00
56.00	05600	RADIOISOTOPE	37	944	0	12	0	56.00
57.00	05700	CT SCAN	93	701	0	22	0	57.00
58.00	05800	MRI	103	408	0	14	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	149	2,561	1,564	74	371	59.00
60.00	06000	LABORATORY	100	7,098	40	181	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,061	2,583	60	355	64.00
65.00	06500	RESPIRATORY THERAPY	333	1,251	0	60	0	65.00
66.00	06600	PHYSICAL THERAPY	41	4,761	28,939	307	0	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	8	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	29	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	723	0	19	0	68.00
69.00	06900	ELECTROCARDIOLOGY	149	5,999	9,364	81	594	69.00
69.01	06901	CARDIAC REHABILITATION	41	0	0	20	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	107	2,205	4,895	17	278	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	69	0	0	67	1,372	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	11,039	3,033	754	138	90.00
91.00	09100	EMERGENCY	62	5,948	84,167	548	4,756	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,469	216,191	570,356	6,229	99,642	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	328	0	7	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	9,137	394	0	192.00
194.00	07950	NONREIMBURSABLE	0	43,004	0	87	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	8,398,739	995,371	2,204,913	696,947	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	32.362215	1.717658	328.258598	6.994510	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,613,099	169,662	213,737	75,967	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	6.215630	0.292777	31.820307	0.762399	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	MAINTENANCE & REPAIRS (HOURS OF SERVICE)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OFL AUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	CAFETERIA (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (FULL TIME EQUIVALENT)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			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	493					11.00
13.00	01300	NURSING ADMINISTRATION	11	1,005,573				13.00
14.00	01400	CENTRAL SERVICE & SUPPLY	2	4,126	4,125,763			14.00
15.00	01500	PHARMACY	15	31,692	12,203	2,065,225		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13	27,475	119	0	100	16.00
17.00	01700	SOCIAL SERVICE	11	23,788	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	128	265,253	531,399	0	7	30.00
31.00	03100	INTENSIVE CARE UNIT	27	55,462	189,623	0	1	31.00
40.00	04000	SUBPROVIDER - IPF	36	74,081	15,124	0	1	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36	74,219	2,162,989	0	10	50.00
51.00	05100	RECOVERY ROOM	5	9,415	15,204	0	1	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	1	52.00
53.00	05300	ANESTHESIOLOGY	1	2,510	116,130	0	2	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18	37,680	44,576	0	5	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	7	14,231	3,735	0	2	55.00
56.00	05600	RADIOISOTOPE	2	4,778	2,453	0	3	56.00
57.00	05700	CT SCAN	6	11,501	40,915	0	10	57.00
58.00	05800	MRI	2	5,113	31,123	0	2	58.00
59.00	05900	CARDIAC CATHETERIZATION	3	6,179	158,497	0	1	59.00
60.00	06000	LABORATORY	36	74,921	55,629	0	19	60.00
64.00	06400	INTRAVENOUS THERAPY	4	8,493	52,192	0	1	64.00
65.00	06500	RESPIRATORY THERAPY	22	45,905	55,074	0	4	65.00
66.00	06600	PHYSICAL THERAPY	18	37,877	12,063	0	2	66.00
66.01	06601	CLINICAL NUTRITION	4	7,598	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	2	3,627	454	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2	3,401	893	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12	24,916	17,323	0	5	69.00
69.01	06901	CARDIAC REHABILITATION	2	3,141	935	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2	4,597	2,269	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	1	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	1	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,065,225	9	73.00
74.00	07400	RENAL DIALYSIS	0	0	2,612	0	0	74.00
76.00	03330	ENDOSCOPY	6	12,037	128,076	0	2	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	25	50,968	96,277	0	2	90.00
91.00	09100	EMERGENCY	35	72,277	377,850	0	8	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	493	997,261	4,125,737	2,065,225	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	2,157	10	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	11	0	0	192.00
194.00	07950	NONREIMBURSABLE	0	6,155	5	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,849,592	1,633,701	371,619	2,300,156	1,422,742	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,751.707911	1.624647	0.090073	1.113756	14,227.420000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	194,670	192,664	13,482	78,971	128,803	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	394.868154	0.191596	0.003268	0.038238	1,288.030000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	CAFETERIA (FULL TIME EQUIVALENT)	NURSING ADMINISTRATION (FULL TIME EQUIVALENT)	CENTRAL SERVICE & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT) 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 SERVICE & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	66	30.00
31.00	03100	INTENSIVE CARE UNIT	10	31.00
40.00	04000	SUBPROVIDER - IPF	24	40.00
43.00	04300	NURSERY	0	43.00
		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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
66.01	06601	CLINICAL NUTRITION	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	0	76.00
		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		92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF	0	99.10
99.20	09920	OPT	0	99.20
		SPECIAL PURPOSE COST CENTERS		
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT FLOWER COFFEE SHOP & CAN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	NONREIMBURSABLE	0	194.00
194.01	07951	RETAIL PHARMACY	0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,728,108	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17,281.080000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	89,007	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	890.070000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)		
			17.00		
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/18/2018 12:29 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total 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	16,064,028		16,064,028	0	16,064,028	30.00
31.00	03100	INTENSIVE CARE UNIT	4,612,549		4,612,549	0	4,612,549	31.00
40.00	04000	SUBPROVIDER - IPF	4,561,282		4,561,282	0	4,561,282	40.00
43.00	04300	NURSERY	357,390		357,390	0	357,390	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,388,531		7,388,531	0	7,388,531	50.00
51.00	05100	RECOVERY ROOM	610,910		610,910	0	610,910	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,545,119		1,545,119	0	1,545,119	52.00
53.00	05300	ANESTHESIOLOGY	578,302		578,302	0	578,302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,775,387		2,775,387	0	2,775,387	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,251,566		1,251,566	0	1,251,566	55.00
56.00	05600	RADIOISOTOPE	939,738		939,738	0	939,738	56.00
57.00	05700	CT SCAN	816,848		816,848	0	816,848	57.00
58.00	05800	MRI	335,255		335,255	0	335,255	58.00
59.00	05900	CARDIAC CATHETERIZATION	561,001		561,001	0	561,001	59.00
60.00	06000	LABORATORY	6,845,489		6,845,489	0	6,845,489	60.00
64.00	06400	INTRAVENOUS THERAPY	527,155		527,155	0	527,155	64.00
65.00	06500	RESPIRATORY THERAPY	2,208,792	0	2,208,792	2,364	2,211,156	65.00
66.00	06600	PHYSICAL THERAPY	2,858,516	0	2,858,516	0	2,858,516	66.00
66.01	06601	CLINICAL NUTRITION	316,723	0	316,723	0	316,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	241,874	0	241,874	0	241,874	67.00
68.00	06800	SPEECH PATHOLOGY	220,321	0	220,321	0	220,321	68.00
69.00	06900	ELECTROCARDIOLOGY	1,970,967		1,970,967	0	1,970,967	69.00
69.01	06901	CARDIAC REHABILITATION	144,389		144,389	0	144,389	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	342,907		342,907	2,364	345,271	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,919,759		3,919,759	0	3,919,759	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	946,388		946,388	0	946,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,966,962		6,966,962	0	6,966,962	73.00
74.00	07400	RENAL DIALYSIS	163,834		163,834	0	163,834	74.00
76.00	03330	ENDOSCOPY	730,983		730,983	46,127	777,110	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,773,309		3,773,309	0	3,773,309	90.00
91.00	09100	EMERGENCY	4,678,113		4,678,113	0	4,678,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,218,610		2,218,610		2,218,610	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OPT	0		0		0	99.20
200.00		Subtotal (see instructions)	81,472,997	0	81,472,997	50,855	81,523,852	200.00
201.00		Less Observation Beds	2,218,610		2,218,610		2,218,610	201.00
202.00		Total (see instructions)	79,254,387	0	79,254,387	50,855	79,305,242	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/18/2018 12:29 pm

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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	18,510,763		18,510,763			30.00
31.00	03100	INTENSIVE CARE UNIT	3,985,022		3,985,022			31.00
40.00	04000	SUBPROVIDER - IPF	4,444,975		4,444,975			40.00
43.00	04300	NURSERY	497,092		497,092			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,212,380	19,581,594	29,793,974	0.247987	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,761,886	2,599,913	4,361,799	0.140059	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,451,093	1,058,418	3,509,511	0.440266	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,530,409	2,887,423	5,417,832	0.106740	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,008,889	10,258,567	13,267,456	0.209188	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,002	4,778,174	4,806,176	0.260408	0.000000	55.00
56.00	05600	RADIOISOTOPE	675,487	6,789,932	7,465,419	0.125879	0.000000	56.00
57.00	05700	CT SCAN	7,723,314	22,584,538	30,307,852	0.026952	0.000000	57.00
58.00	05800	MRI	858,403	5,650,222	6,508,625	0.051509	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	391,677	1,151,670	1,543,347	0.363496	0.000000	59.00
60.00	06000	LABORATORY	21,377,901	32,574,067	53,951,968	0.126881	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	19,231	2,343,935	2,363,166	0.223072	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,904,094	4,355,921	11,260,015	0.196162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,444,002	5,201,107	6,645,109	0.430168	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	374	155,097	155,471	2.037184	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	216,196	592,010	808,206	0.299273	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	175,621	211,146	386,767	0.569648	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,814,124	9,032,197	14,846,321	0.132758	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	540,374	540,374	0.267202	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	222,619	763,059	985,678	0.347889	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,199,872	583,341	3,783,213	1.036093	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,105,872	714,502	1,820,374	0.519887	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,612,882	13,093,584	26,706,466	0.260872	0.000000	73.00
74.00	07400	RENAL DIALYSIS	387,182	39,522	426,704	0.383952	0.000000	74.00
76.00	03330	ENDOSCOPY	400,011	5,476,165	5,876,176	0.124398	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,468	5,288,200	5,311,668	0.710381	0.000000	90.00
91.00	09100	EMERGENCY	6,073,675	18,797,613	24,871,288	0.188093	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	349,208	1,720,577	2,069,785	1.071904	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
200.00		Subtotal (see instructions)	118,405,724	178,822,868	297,228,592			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	118,405,724	178,822,868	297,228,592			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/18/2018 12:29 pm

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.247987		50.00
51.00	05100	RECOVERY ROOM	0.140059		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266		52.00
53.00	05300	ANESTHESIOLOGY	0.106740		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408		55.00
56.00	05600	RADIOISOTOPE	0.125879		56.00
57.00	05700	CT SCAN	0.026952		57.00
58.00	05800	MRI	0.051509		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496		59.00
60.00	06000	LABORATORY	0.126881		60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072		64.00
65.00	06500	RESPIRATORY THERAPY	0.196372		65.00
66.00	06600	PHYSICAL THERAPY	0.430168		66.00
66.01	06601	CLINICAL NUTRITION	2.037184		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273		67.00
68.00	06800	SPEECH PATHOLOGY	0.569648		68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758		69.00
69.01	06901	CARDIAC REHABILITATION	0.267202		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350288		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872		73.00
74.00	07400	RENAL DIALYSIS	0.383952		74.00
76.00	03330	ENDOSCOPY	0.132248		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.710381		90.00
91.00	09100	EMERGENCY	0.188093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
99.20	09920	OPT			99.20
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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/18/2018 12:29 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,064,028		16,064,028	0	16,064,028	30.00
31.00	03100	INTENSIVE CARE UNIT	4,612,549		4,612,549	0	4,612,549	31.00
40.00	04000	SUBPROVIDER - IPF	4,561,282		4,561,282	0	4,561,282	40.00
43.00	04300	NURSERY	357,390		357,390	0	357,390	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,388,531		7,388,531	0	7,388,531	50.00
51.00	05100	RECOVERY ROOM	610,910		610,910	0	610,910	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,545,119		1,545,119	0	1,545,119	52.00
53.00	05300	ANESTHESIOLOGY	578,302		578,302	0	578,302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,775,387		2,775,387	0	2,775,387	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,251,566		1,251,566	0	1,251,566	55.00
56.00	05600	RADIOISOTOPE	939,738		939,738	0	939,738	56.00
57.00	05700	CT SCAN	816,848		816,848	0	816,848	57.00
58.00	05800	MRI	335,255		335,255	0	335,255	58.00
59.00	05900	CARDIAC CATHETERIZATION	561,001		561,001	0	561,001	59.00
60.00	06000	LABORATORY	6,845,489		6,845,489	0	6,845,489	60.00
64.00	06400	INTRAVENOUS THERAPY	527,155		527,155	0	527,155	64.00
65.00	06500	RESPIRATORY THERAPY	2,208,792	0	2,208,792	2,364	2,211,156	65.00
66.00	06600	PHYSICAL THERAPY	2,858,516	0	2,858,516	0	2,858,516	66.00
66.01	06601	CLINICAL NUTRITION	316,723	0	316,723	0	316,723	66.01
67.00	06700	OCCUPATIONAL THERAPY	241,874	0	241,874	0	241,874	67.00
68.00	06800	SPEECH PATHOLOGY	220,321	0	220,321	0	220,321	68.00
69.00	06900	ELECTROCARDIOLOGY	1,970,967		1,970,967	0	1,970,967	69.00
69.01	06901	CARDIAC REHABILITATION	144,389		144,389	0	144,389	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	342,907		342,907	2,364	345,271	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,919,759		3,919,759	0	3,919,759	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	946,388		946,388	0	946,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,966,962		6,966,962	0	6,966,962	73.00
74.00	07400	RENAL DIALYSIS	163,834		163,834	0	163,834	74.00
76.00	03330	ENDOSCOPY	730,983		730,983	46,127	777,110	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,773,309		3,773,309	0	3,773,309	90.00
91.00	09100	EMERGENCY	4,678,113		4,678,113	0	4,678,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,218,610		2,218,610		2,218,610	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OPT	0		0		0	99.20
200.00		Subtotal (see instructions)	81,472,997	0	81,472,997	50,855	81,523,852	200.00
201.00		Less Observation Beds	2,218,610		2,218,610		2,218,610	201.00
202.00		Total (see instructions)	79,254,387	0	79,254,387	50,855	79,305,242	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/18/2018 12:29 pm

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	18,510,763		18,510,763			30.00
31.00	03100	INTENSIVE CARE UNIT	3,985,022		3,985,022			31.00
40.00	04000	SUBPROVIDER - IPF	4,444,975		4,444,975			40.00
43.00	04300	NURSERY	497,092		497,092			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,212,380	19,581,594	29,793,974	0.247987	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,761,886	2,599,913	4,361,799	0.140059	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,451,093	1,058,418	3,509,511	0.440266	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,530,409	2,887,423	5,417,832	0.106740	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,008,889	10,258,567	13,267,456	0.209188	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	28,002	4,778,174	4,806,176	0.260408	0.000000	55.00
56.00	05600	RADIOISOTOPE	675,487	6,789,932	7,465,419	0.125879	0.000000	56.00
57.00	05700	CT SCAN	7,723,314	22,584,538	30,307,852	0.026952	0.000000	57.00
58.00	05800	MRI	858,403	5,650,222	6,508,625	0.051509	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	391,677	1,151,670	1,543,347	0.363496	0.000000	59.00
60.00	06000	LABORATORY	21,377,901	32,574,067	53,951,968	0.126881	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	19,231	2,343,935	2,363,166	0.223072	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	6,904,094	4,355,921	11,260,015	0.196162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,444,002	5,201,107	6,645,109	0.430168	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	374	155,097	155,471	2.037184	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	216,196	592,010	808,206	0.299273	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	175,621	211,146	386,767	0.569648	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,814,124	9,032,197	14,846,321	0.132758	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	540,374	540,374	0.267202	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	222,619	763,059	985,678	0.347889	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,199,872	583,341	3,783,213	1.036093	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,105,872	714,502	1,820,374	0.519887	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,612,882	13,093,584	26,706,466	0.260872	0.000000	73.00
74.00	07400	RENAL DIALYSIS	387,182	39,522	426,704	0.383952	0.000000	74.00
76.00	03330	ENDOSCOPY	400,011	5,476,165	5,876,176	0.124398	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	23,468	5,288,200	5,311,668	0.710381	0.000000	90.00
91.00	09100	EMERGENCY	6,073,675	18,797,613	24,871,288	0.188093	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	349,208	1,720,577	2,069,785	1.071904	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OPT	0	0	0			99.20
200.00		Subtotal (see instructions)	118,405,724	178,822,868	297,228,592			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	118,405,724	178,822,868	297,228,592			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/18/2018 12:29 pm

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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.247987		50.00
51.00	05100	RECOVERY ROOM	0.140059		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266		52.00
53.00	05300	ANESTHESIOLOGY	0.106740		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408		55.00
56.00	05600	RADIOISOTOPE	0.125879		56.00
57.00	05700	CT SCAN	0.026952		57.00
58.00	05800	MRI	0.051509		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496		59.00
60.00	06000	LABORATORY	0.126881		60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072		64.00
65.00	06500	RESPIRATORY THERAPY	0.196372		65.00
66.00	06600	PHYSICAL THERAPY	0.430168		66.00
66.01	06601	CLINICAL NUTRITION	2.037184		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273		67.00
68.00	06800	SPEECH PATHOLOGY	0.569648		68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758		69.00
69.01	06901	CARDIAC REHABILITATION	0.267202		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350288		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872		73.00
74.00	07400	RENAL DIALYSIS	0.383952		74.00
76.00	03330	ENDOSCOPY	0.132248		76.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.710381		90.00
91.00	09100	EMERGENCY	0.188093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
99.20	09920	OPT			99.20
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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/18/2018 12:29 pm

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	7,388,531	1,230,210	6,158,321	0	0	50.00
51.00	05100	RECOVERY ROOM	610,910	24,853	586,057	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,545,119	158,578	1,386,541	0	0	52.00
53.00	05300	ANESTHESIOLOGY	578,302	37,236	541,066	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,775,387	463,558	2,311,829	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,251,566	192,997	1,058,569	0	0	55.00
56.00	05600	RADIOISOTOPE	939,738	57,987	881,751	0	0	56.00
57.00	05700	CT SCAN	816,848	73,044	743,804	0	0	57.00
58.00	05800	MRI	335,255	33,430	301,825	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	561,001	85,070	475,931	0	0	59.00
60.00	06000	LABORATORY	6,845,489	385,080	6,460,409	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	527,155	37,938	489,217	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,208,792	140,372	2,068,420	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,858,516	269,097	2,589,419	0	0	66.00
66.01	06601	CLINICAL NUTRITION	316,723	11,535	305,188	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	241,874	8,705	233,169	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	220,321	19,562	200,759	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,970,967	248,648	1,722,319	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	144,389	6,059	138,330	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	342,907	50,975	291,932	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,919,759	111,701	3,808,058	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	946,388	27,641	918,747	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,966,962	218,877	6,748,085	0	0	73.00
74.00	07400	RENAL DIALYSIS	163,834	4,634	159,200	0	0	74.00
76.00	03330	ENDOSCOPY	730,983	31,576	699,407	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,773,309	393,414	3,379,895	0	0	90.00
91.00	09100	EMERGENCY	4,678,113	318,409	4,359,704	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,218,610	240,386	1,978,224	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OPT	0	0	0	0	0	99.20
200.00		Subtotal (sum of lines 50 thru 199)	55,877,748	4,881,572	50,996,176	0	0	200.00
201.00		Less Observation Beds	2,218,610	240,386	1,978,224	0	0	201.00
202.00		Total (line 200 minus line 201)	53,659,138	4,641,186	49,017,952	0	0	202.00

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

Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part II | Date/Time Prepared: 5/18/2018 12:29 pm

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	7,388,531	29,793,974	0.247987		50.00
51.00	05100	RECOVERY ROOM	610,910	4,361,799	0.140059		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,545,119	3,509,511	0.440266		52.00
53.00	05300	ANESTHESIOLOGY	578,302	5,417,832	0.106740		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,775,387	13,267,456	0.209188		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,251,566	4,806,176	0.260408		55.00
56.00	05600	RADIOISOTOPE	939,738	7,465,419	0.125879		56.00
57.00	05700	CT SCAN	816,848	30,307,852	0.026952		57.00
58.00	05800	MRI	335,255	6,508,625	0.051509		58.00
59.00	05900	CARDIAC CATHETERIZATION	561,001	1,543,347	0.363496		59.00
60.00	06000	LABORATORY	6,845,489	53,951,968	0.126881		60.00
64.00	06400	INTRAVENOUS THERAPY	527,155	2,363,166	0.223072		64.00
65.00	06500	RESPIRATORY THERAPY	2,208,792	11,260,015	0.196162		65.00
66.00	06600	PHYSICAL THERAPY	2,858,516	6,645,109	0.430168		66.00
66.01	06601	CLINICAL NUTRITION	316,723	155,471	2.037184		66.01
67.00	06700	OCCUPATIONAL THERAPY	241,874	808,206	0.299273		67.00
68.00	06800	SPEECH PATHOLOGY	220,321	386,767	0.569648		68.00
69.00	06900	ELECTROCARDIOLOGY	1,970,967	14,846,321	0.132758		69.00
69.01	06901	CARDIAC REHABILITATION	144,389	540,374	0.267202		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	342,907	985,678	0.347889		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	3,919,759	3,783,213	1.036093		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	946,388	1,820,374	0.519887		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,966,962	26,706,466	0.260872		73.00
74.00	07400	RENAL DIALYSIS	163,834	426,704	0.383952		74.00
76.00	03330	ENDOSCOPY	730,983	5,876,176	0.124398		76.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	3,773,309	5,311,668	0.710381		90.00
91.00	09100	EMERGENCY	4,678,113	24,871,288	0.188093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	2,218,610	2,069,785	1.071904		92.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0.000000		99.10
99.20	09920	OPT	0	0	0.000000		99.20
200.00		Subtotal (sum of lines 50 thru 199)	55,877,748	269,790,740			200.00
201.00		Less Observation Beds	2,218,610	0			201.00
202.00		Total (line 200 minus line 201)	53,659,138	269,790,740			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/18/2018 12:29 pm

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	1,740,534	0	1,740,534	15,741	110.57	30.00
31.00	INTENSIVE CARE UNIT	347,517		347,517	2,149	161.71	31.00
40.00	SUBPROVIDER - IPF	321,719	0	321,719	4,747	67.77	40.00
43.00	NURSERY	74,720		74,720	478	156.32	43.00
200.00	Total (lines 30 through 199)	2,484,490		2,484,490	23,115		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	9,377	1,036,815				30.00
31.00	INTENSIVE CARE UNIT	980	158,476				31.00
40.00	SUBPROVIDER - IPF	1,388	94,065				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	11,745	1,289,356				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/18/2018 12:29 pm

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	1,230,210	29,793,974	0.041291	5,979,025	246,880	50.00
51.00	05100	RECOVERY ROOM	24,853	4,361,799	0.005698	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	158,578	3,509,511	0.045185	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,236	5,417,832	0.006873	899,899	6,185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,558	13,267,456	0.034939	1,930,914	67,464	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	192,997	4,806,176	0.040156	0	0	55.00
56.00	05600	RADIOISOTOPE	57,987	7,465,419	0.007767	459,341	3,568	56.00
57.00	05700	CT SCAN	73,044	30,307,852	0.002410	4,392,532	10,586	57.00
58.00	05800	MRI	33,430	6,508,625	0.005136	477,800	2,454	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,070	1,543,347	0.055120	88,414	4,873	59.00
60.00	06000	LABORATORY	385,080	53,951,968	0.007137	13,039,326	93,062	60.00
64.00	06400	INTRAVENOUS THERAPY	37,938	2,363,166	0.016054	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	140,372	11,260,015	0.012466	4,463,429	55,641	65.00
66.00	06600	PHYSICAL THERAPY	269,097	6,645,109	0.040495	1,261,674	51,091	66.00
66.01	06601	CLINICAL NUTRITION	11,535	155,471	0.074194	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	8,705	808,206	0.010771	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,562	386,767	0.050578	134,072	6,781	68.00
69.00	06900	ELECTROCARDIOLOGY	248,648	14,846,321	0.016748	3,950,029	66,155	69.00
69.01	06901	CARDIAC REHABILITATION	6,059	540,374	0.011213	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,975	985,678	0.051716	1,118	58	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	111,701	3,783,213	0.029525	2,254,173	66,554	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,641	1,820,374	0.015184	546,643	8,300	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,877	26,706,466	0.008196	8,397,461	68,826	73.00
74.00	07400	RENAL DIALYSIS	4,634	426,704	0.010860	303,240	3,293	74.00
76.00	03330	ENDOSCOPY	31,576	5,876,176	0.005374	2,260	12	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	393,414	5,311,668	0.074066	450	33	90.00
91.00	09100	EMERGENCY	318,409	24,871,288	0.012802	3,258,865	41,720	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	240,386	2,069,785	0.116141	234,274	27,209	92.00
200.00		Total (lines 50 through 199)	4,881,572	269,790,740		52,074,939	830,745	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/18/2018 12:29 pm

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
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	15,741	0.00	9,377	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,149	0.00	980	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,747	0.00	1,388	40.00
43.00	04300	NURSERY		0	478	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	23,115		11,745	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	0	0	0	0	0	76.00
		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	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/18/2018 12:29 pm

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	29,793,974	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,361,799	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,509,511	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,417,832	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,267,456	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,806,176	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,465,419	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	30,307,852	0.000000	57.00
58.00	05800	MRI	0	0	0	6,508,625	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,543,347	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	53,951,968	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,363,166	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,260,015	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,645,109	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	155,471	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	808,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	386,767	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,846,321	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	540,374	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	985,678	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,783,213	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,820,374	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,706,466	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	426,704	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	5,876,176	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,311,668	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,871,288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,069,785	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	269,790,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/18/2018 12:29 pm

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	5,979,025	0	9,956,616	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	899,899	0	1,014,739	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,930,914	0	5,647,645	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	459,341	0	3,166,760	0	56.00
57.00	05700	CT SCAN	0.000000	4,392,532	0	7,650,368	0	57.00
58.00	05800	MRI	0.000000	477,800	0	1,697,300	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	88,414	0	284,077	0	59.00
60.00	06000	LABORATORY	0.000000	13,039,326	0	6,547,133	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	222,849	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,463,429	0	1,706,619	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,261,674	0	66,430	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	134,072	0	96,222	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,950,029	0	4,052,782	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	304,920	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,118	0	38,288	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	2,254,173	0	273,297	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	546,643	0	318,156	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	8,397,461	0	8,250,982	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	303,240	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	2,260	0	30,590	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	450	0	1,304,138	0	90.00
91.00	09100	EMERGENCY	0.000000	3,258,865	0	4,938,628	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	234,274	0	1,013,028	0	92.00
200.00		Total (lines 50 through 199)		52,074,939	0	58,581,567	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/18/2018 12:29 pm

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	0.247987	9,956,616	0	0	2,469,111	50.00
51.00	05100	RECOVERY ROOM	0.140059	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106740	1,014,739	0	0	108,313	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188	5,647,645	0	0	1,181,420	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.125879	3,166,760	0	0	398,629	56.00
57.00	05700	CT SCAN	0.026952	7,650,368	0	0	206,193	57.00
58.00	05800	MRI	0.051509	1,697,300	0	0	87,426	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496	284,077	0	0	103,261	59.00
60.00	06000	LABORATORY	0.126881	6,547,133	260	0	830,707	60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072	222,849	0	0	49,711	64.00
65.00	06500	RESPIRATORY THERAPY	0.196162	1,706,619	0	0	334,774	65.00
66.00	06600	PHYSICAL THERAPY	0.430168	66,430	0	0	28,576	66.00
66.01	06601	CLINICAL NUTRITION	2.037184	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.569648	96,222	0	0	54,813	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758	4,052,782	0	0	538,039	69.00
69.01	06901	CARDIAC REHABILITATION	0.267202	304,920	0	0	81,475	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.347889	38,288	0	0	13,320	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093	273,297	0	0	283,161	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887	318,156	0	0	165,405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872	8,250,982	0	256,900	2,152,450	73.00
74.00	07400	RENAL DIALYSIS	0.383952	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.124398	30,590	0	0	3,805	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.710381	1,304,138	0	0	926,435	90.00
91.00	09100	EMERGENCY	0.188093	4,938,628	0	0	928,921	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904	1,013,028	0	0	1,085,869	92.00
200.00		Subtotal (see instructions)		58,581,567	260	256,900	12,031,814	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		58,581,567	260	256,900	12,031,814	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	33	0		60.00
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
66.01	06601	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	67,018		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
		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	0	0		92.00
200.00		Subtotal (see instructions)	33	67,018		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	33	67,018		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/18/2018 12:29 pm

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	1,230,210	29,793,974	0.041291	0	0	50.00
51.00	05100	RECOVERY ROOM	24,853	4,361,799	0.005698	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	158,578	3,509,511	0.045185	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,236	5,417,832	0.006873	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,558	13,267,456	0.034939	13,973	488	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	192,997	4,806,176	0.040156	0	0	55.00
56.00	05600	RADIOISOTOPE	57,987	7,465,419	0.007767	0	0	56.00
57.00	05700	CT SCAN	73,044	30,307,852	0.002410	46,450	112	57.00
58.00	05800	MRI	33,430	6,508,625	0.005136	9,400	48	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,070	1,543,347	0.055120	0	0	59.00
60.00	06000	LABORATORY	385,080	53,951,968	0.007137	411,091	2,934	60.00
64.00	06400	INTRAVENOUS THERAPY	37,938	2,363,166	0.016054	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	140,372	11,260,015	0.012466	71,650	893	65.00
66.00	06600	PHYSICAL THERAPY	269,097	6,645,109	0.040495	20,868	845	66.00
66.01	06601	CLINICAL NUTRITION	11,535	155,471	0.074194	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	8,705	808,206	0.010771	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,562	386,767	0.050578	916	46	68.00
69.00	06900	ELECTROCARDIOLOGY	248,648	14,846,321	0.016748	16,212	272	69.00
69.01	06901	CARDIAC REHABILITATION	6,059	540,374	0.011213	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,975	985,678	0.051716	6,565	340	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	111,701	3,783,213	0.029525	2,800	83	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,641	1,820,374	0.015184	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,877	26,706,466	0.008196	128,846	1,056	73.00
74.00	07400	RENAL DIALYSIS	4,634	426,704	0.010860	0	0	74.00
76.00	03330	ENDOSCOPY	31,576	5,876,176	0.005374	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	393,414	5,311,668	0.074066	1,519	113	90.00
91.00	09100	EMERGENCY	318,409	24,871,288	0.012802	166,989	2,138	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,069,785	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,641,186	269,790,740		897,279	9,368	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	0	0	0	0	0	76.00
		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	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: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/18/2018 12:29 pm

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	29,793,974	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,361,799	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,509,511	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,417,832	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,267,456	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,806,176	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,465,419	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	30,307,852	0.000000	57.00
58.00	05800	MRI	0	0	0	6,508,625	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,543,347	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	53,951,968	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,363,166	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,260,015	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,645,109	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	155,471	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	808,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	386,767	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,846,321	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	540,374	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	985,678	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,783,213	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,820,374	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,706,466	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	426,704	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	5,876,176	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,311,668	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,871,288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,069,785	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	269,790,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/18/2018 12:29 pm

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	13,973	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	46,450	0	0	0	57.00
58.00	05800	MRI	0.000000	9,400	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	411,091	0	644	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	71,650	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	20,868	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	916	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	16,212	0	353	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	6,565	0	855	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	2,800	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	128,846	0	555	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.000000	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	1,519	0	337,100	0	90.00
91.00	09100	EMERGENCY	0.000000	166,989	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.000000	0	0	200	0	92.00
200.00		Total (lines 50 through 199)		897,279	0	339,707	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/18/2018 12:29 pm

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	0.247987	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.140059	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106740	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.125879	0	0	0	0	56.00
57.00	05700	CT SCAN	0.026952	0	0	0	0	57.00
58.00	05800	MRI	0.051509	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496	0	0	0	0	59.00
60.00	06000	LABORATORY	0.126881	644	0	0	82	60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196162	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.430168	0	0	0	0	66.00
66.01	06601	CLINICAL NUTRITION	2.037184	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.569648	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758	353	0	0	47	69.00
69.01	06901	CARDIAC REHABILITATION	0.267202	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.347889	855	0	0	297	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872	555	0	0	145	73.00
74.00	07400	RENAL DIALYSIS	0.383952	0	0	0	0	74.00
76.00	03330	ENDOSCOPY	0.124398	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.710381	337,100	0	0	239,469	90.00
91.00	09100	EMERGENCY	0.188093	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904	200	0	0	214	92.00
200.00		Subtotal (see instructions)		339,707	0	0	240,254	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		339,707	0	0	240,254	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
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
66.01	06601	CLINICAL NUTRITION	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	CARDIAC REHABILITATION	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03330	ENDOSCOPY	0	0		76.00
		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	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/18/2018 12:29 pm

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	1,740,534	0	1,740,534	15,741	110.57	30.00
31.00	INTENSIVE CARE UNIT	347,517		347,517	2,149	161.71	31.00
40.00	SUBPROVIDER - IPF	321,719	0	321,719	4,747	67.77	40.00
43.00	NURSERY	74,720		74,720	478	156.32	43.00
200.00	Total (lines 30 through 199)	2,484,490		2,484,490	23,115		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,677	185,426				30.00
31.00	INTENSIVE CARE UNIT	399	64,522				31.00
40.00	SUBPROVIDER - IPF	2,315	156,888				40.00
43.00	NURSERY	323	50,491				43.00
200.00	Total (lines 30 through 199)	4,714	457,327				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/18/2018 12:29 pm

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	1,230,210	29,793,974	0.041291	0	0	50.00
51.00	05100	RECOVERY ROOM	24,853	4,361,799	0.005698	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	158,578	3,509,511	0.045185	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,236	5,417,832	0.006873	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,558	13,267,456	0.034939	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	192,997	4,806,176	0.040156	0	0	55.00
56.00	05600	RADIOISOTOPE	57,987	7,465,419	0.007767	0	0	56.00
57.00	05700	CT SCAN	73,044	30,307,852	0.002410	0	0	57.00
58.00	05800	MRI	33,430	6,508,625	0.005136	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,070	1,543,347	0.055120	0	0	59.00
60.00	06000	LABORATORY	385,080	53,951,968	0.007137	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	37,938	2,363,166	0.016054	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	140,372	11,260,015	0.012466	0	0	65.00
66.00	06600	PHYSICAL THERAPY	269,097	6,645,109	0.040495	0	0	66.00
66.01	06601	CLINICAL NUTRITION	11,535	155,471	0.074194	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	8,705	808,206	0.010771	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,562	386,767	0.050578	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	248,648	14,846,321	0.016748	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	6,059	540,374	0.011213	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,975	985,678	0.051716	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	111,701	3,783,213	0.029525	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,641	1,820,374	0.015184	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,877	26,706,466	0.008196	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,634	426,704	0.010860	0	0	74.00
76.00	03330	ENDOSCOPY	31,576	5,876,176	0.005374	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	393,414	5,311,668	0.074066	0	0	90.00
91.00	09100	EMERGENCY	318,409	24,871,288	0.012802	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	240,386	2,069,785	0.116141	0	0	92.00
200.00		Total (lines 50 through 199)	4,881,572	269,790,740		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/18/2018 12:29 pm

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
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	15,741	0.00	1,677	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,149	0.00	399	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,747	0.00	2,315	40.00
43.00	04300	NURSERY		0	478	0.00	323	43.00
200.00		Total (lines 30 through 199)		0	23,115		4,714	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	0	0	0	0	0	76.00
		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	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/18/2018 12:29 pm

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	29,793,974	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,361,799	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,509,511	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,417,832	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,267,456	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,806,176	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,465,419	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	30,307,852	0.000000	57.00
58.00	05800	MRI	0	0	0	6,508,625	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,543,347	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	53,951,968	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,363,166	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,260,015	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,645,109	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	155,471	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	808,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	386,767	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,846,321	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	540,374	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	985,678	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,783,213	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,820,374	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,706,466	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	426,704	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	5,876,176	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,311,668	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,871,288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,069,785	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	269,790,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
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
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	0.000000	0	0	0	0	76.00
		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	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: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/18/2018 12:29 pm

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	1,230,210	29,793,974	0.041291	0	0	50.00
51.00	05100	RECOVERY ROOM	24,853	4,361,799	0.005698	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	158,578	3,509,511	0.045185	0	0	52.00
53.00	05300	ANESTHESIOLOGY	37,236	5,417,832	0.006873	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	463,558	13,267,456	0.034939	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	192,997	4,806,176	0.040156	0	0	55.00
56.00	05600	RADIOISOTOPE	57,987	7,465,419	0.007767	0	0	56.00
57.00	05700	CT SCAN	73,044	30,307,852	0.002410	0	0	57.00
58.00	05800	MRI	33,430	6,508,625	0.005136	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	85,070	1,543,347	0.055120	0	0	59.00
60.00	06000	LABORATORY	385,080	53,951,968	0.007137	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	37,938	2,363,166	0.016054	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	140,372	11,260,015	0.012466	0	0	65.00
66.00	06600	PHYSICAL THERAPY	269,097	6,645,109	0.040495	0	0	66.00
66.01	06601	CLINICAL NUTRITION	11,535	155,471	0.074194	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	8,705	808,206	0.010771	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,562	386,767	0.050578	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	248,648	14,846,321	0.016748	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	6,059	540,374	0.011213	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,975	985,678	0.051716	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	111,701	3,783,213	0.029525	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	27,641	1,820,374	0.015184	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	218,877	26,706,466	0.008196	0	0	73.00
74.00	07400	RENAL DIALYSIS	4,634	426,704	0.010860	0	0	74.00
76.00	03330	ENDOSCOPY	31,576	5,876,176	0.005374	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	393,414	5,311,668	0.074066	0	0	90.00
91.00	09100	EMERGENCY	318,409	24,871,288	0.012802	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	2,069,785	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	4,641,186	269,790,740		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
66.01	06601	CLINICAL NUTRITION	0	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	0	0	0	0	0	76.00
		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	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: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/18/2018 12:29 pm

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	29,793,974	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,361,799	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,509,511	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,417,832	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,267,456	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	4,806,176	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,465,419	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	30,307,852	0.000000	57.00
58.00	05800	MRI	0	0	0	6,508,625	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,543,347	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	53,951,968	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,363,166	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,260,015	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,645,109	0.000000	66.00
66.01	06601	CLINICAL NUTRITION	0	0	0	155,471	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	808,206	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	386,767	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,846,321	0.000000	69.00
69.01	06901	CARDIAC REHABILITATION	0	0	0	540,374	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	985,678	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	3,783,213	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	1,820,374	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	26,706,466	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	426,704	0.000000	74.00
76.00	03330	ENDOSCOPY	0	0	0	5,876,176	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	5,311,668	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	24,871,288	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	2,069,785	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	269,790,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/18/2018 12:29 pm

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
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
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
66.01	06601	CLINICAL NUTRITION	0.000000	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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	03330	ENDOSCOPY	0.000000	0	0	0	0	76.00
		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	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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)	15,741	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,741	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.	13,525	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	42	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)	9,377	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)	16,064,028	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)	16,064,028	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	18,510,763	28.00
29.00	Private room charges (excluding swing-bed charges)	18,466,337	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	44,426	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.867821	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,365.35	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,057.76	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	307.59	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	266.93	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	3,610,228	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	12,453,800	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,020.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,569,416	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)	9,569,416	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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	4,612,549	2,149	2,146.37	980	2,103,443	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)	11,682,014	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	23,354,873	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,195,291	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	830,745	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,026,036	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,328,837	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)	2,174	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,020.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,218,610	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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	1,740,534	16,064,028	0.108350	2,218,610	240,386	90.00
91.00	Nursing School cost	0	16,064,028	0.000000	2,218,610	0	91.00
92.00	Allied health cost	0	16,064,028	0.000000	2,218,610	0	92.00
93.00	All other Medical Education	0	16,064,028	0.000000	2,218,610	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/18/2018 12:29 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,747	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,747	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,747	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,388	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,561,282	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,561,282	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,561,282	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)	960.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,333,701	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)	1,333,701	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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)	153,841	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,487,542	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)	94,065	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,368	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	103,433	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,384,109	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 14-S034 | Date/Time Prepared: 5/18/2018 12:29 pm

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	321,719	4,561,282	0.070533	0	0	90.00
91.00	Nursing School cost	0	4,561,282	0.000000	0	0	91.00
92.00	Allied health cost	0	4,561,282	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,561,282	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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)	15,741	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,741	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)	13,567	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,677	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)	478	15.00
16.00	Nursery days (title V or XIX only)	323	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)	16,064,028	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)	16,064,028	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)	16,064,028	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,020.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,711,412	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)	1,711,412	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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)	357,390	478	747.68	323	241,501	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	4,612,549	2,149	2,146.37	399	856,402	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)	2,809,315	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)	300,439	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)	300,439	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,508,876	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)	2,174	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,020.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,218,610	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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	1,740,534	16,064,028	0.108350	2,218,610	240,386	90.00
91.00	Nursing School cost	0	16,064,028	0.000000	2,218,610	0	91.00
92.00	Allied health cost	0	16,064,028	0.000000	2,218,610	0	92.00
93.00	All other Medical Education	0	16,064,028	0.000000	2,218,610	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0034 Component CCN: 14-S034	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/18/2018 12:29 pm
	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)	4,747	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,747	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,747	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)	2,315	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)	478	15.00
16.00	Nursery days (title V or XIX only)	323	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,561,282	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,561,282	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,561,282	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)	960.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,224,437	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)	2,224,437	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/18/2018 12:29 pm

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)	2,224,437	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)	156,888	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)	156,888	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,067,549	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: 14-0034 Component CCN: 14-S034	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/18/2018 12:29 pm
	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	321,719	4,561,282	0.070533	0	0	90.00
91.00	Nursing School cost	0	4,561,282	0.000000	0	0	91.00
92.00	Allied health cost	0	4,561,282	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,561,282	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/18/2018 12:29 pm

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		10,079,319		30.00
31.00	03100	INTENSIVE CARE UNIT		1,755,000		31.00
40.00	04000	SUBPROVIDER - IPF		935		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247987	5,979,025	1,482,720	50.00
51.00	05100	RECOVERY ROOM	0.140059	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106740	899,899	96,055	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188	1,930,914	403,924	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408	0	0	55.00
56.00	05600	RADIOISOTOPE	0.125879	459,341	57,821	56.00
57.00	05700	CT SCAN	0.026952	4,392,532	118,388	57.00
58.00	05800	MRI	0.051509	477,800	24,611	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496	88,414	32,138	59.00
60.00	06000	LABORATORY	0.126881	13,039,326	1,654,443	60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196372	4,463,429	876,492	65.00
66.00	06600	PHYSICAL THERAPY	0.430168	1,261,674	542,732	66.00
66.01	06601	CLINICAL NUTRITION	2.037184	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.569648	134,072	76,374	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758	3,950,029	524,398	69.00
69.01	06901	CARDIAC REHABILITATION	0.267202	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350288	1,118	392	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093	2,254,173	2,335,533	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887	546,643	284,193	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872	8,397,461	2,190,662	73.00
74.00	07400	RENAL DIALYSIS	0.383952	303,240	116,430	74.00
76.00	03330	ENDOSCOPY	0.132248	2,260	299	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.710381	450	320	90.00
91.00	09100	EMERGENCY	0.188093	3,258,865	612,970	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904	234,274	251,119	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		52,074,939	11,682,014	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)		52,074,939		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/18/2018 12:29 pm

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		1,297,780		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247987	0	0	50.00
51.00	05100	RECOVERY ROOM	0.140059	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106740	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188	13,973	2,923	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408	0	0	55.00
56.00	05600	RADIOISOTOPE	0.125879	0	0	56.00
57.00	05700	CT SCAN	0.026952	46,450	1,252	57.00
58.00	05800	MRI	0.051509	9,400	484	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496	0	0	59.00
60.00	06000	LABORATORY	0.126881	411,091	52,160	60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196372	71,650	14,070	65.00
66.00	06600	PHYSICAL THERAPY	0.430168	20,868	8,977	66.00
66.01	06601	CLINICAL NUTRITION	2.037184	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.569648	916	522	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758	16,212	2,152	69.00
69.01	06901	CARDIAC REHABILITATION	0.267202	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350288	6,565	2,300	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093	2,800	2,901	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872	128,846	33,612	73.00
74.00	07400	RENAL DIALYSIS	0.383952	0	0	74.00
76.00	03330	ENDOSCOPY	0.132248	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.710381	1,519	1,079	90.00
91.00	09100	EMERGENCY	0.188093	166,989	31,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		897,279	153,841	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)		897,279		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/18/2018 12:29 pm

Title XIX | 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		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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247987	0	0	50.00
51.00	05100	RECOVERY ROOM	0.140059	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106740	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408	0	0	55.00
56.00	05600	RADIOISOTOPE	0.125879	0	0	56.00
57.00	05700	CT SCAN	0.026952	0	0	57.00
58.00	05800	MRI	0.051509	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496	0	0	59.00
60.00	06000	LABORATORY	0.126881	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.430168	0	0	66.00
66.01	06601	CLINICAL NUTRITION	2.037184	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.569648	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.267202	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350288	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.383952	0	0	74.00
76.00	03330	ENDOSCOPY	0.132248	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.710381	0	0	90.00
91.00	09100	EMERGENCY	0.188093	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/18/2018 12:29 pm

Title XIX | 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		0		40.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.247987	0	0	50.00
51.00	05100	RECOVERY ROOM	0.140059	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.440266	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.106740	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.209188	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.260408	0	0	55.00
56.00	05600	RADIOISOTOPE	0.125879	0	0	56.00
57.00	05700	CT SCAN	0.026952	0	0	57.00
58.00	05800	MRI	0.051509	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.363496	0	0	59.00
60.00	06000	LABORATORY	0.126881	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.223072	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.196372	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.430168	0	0	66.00
66.01	06601	CLINICAL NUTRITION	2.037184	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.299273	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.569648	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.132758	0	0	69.00
69.01	06901	CARDIAC REHABILITATION	0.267202	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.350288	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	1.036093	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.519887	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260872	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.383952	0	0	74.00
76.00	03330	ENDOSCOPY	0.132248	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.710381	0	0	90.00
91.00	09100	EMERGENCY	0.188093	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	1.071904	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/18/2018 12:29 pm
	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)	12,573,999	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	3,753,193	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)	265,467	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)	88.04	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)	4.69	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.81	31.00
32.00	Sum of lines 30 and 31	23.50	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.60	33.00
34.00	Disproportionate share adjustment (see instructions)	351,035	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	5,982,495,714	6,766,678,474	35.00
35.01	Factor 3 (see instructions)	0.000135961	0.000121679	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	812,707	823,363	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	607,860	207,533	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	815,393		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)	17,759,087		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	19,499,159		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	19,064,141	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,330,306	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	1,750	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)	20,396,197	59.00
60.00	Primary payer payments	18,103	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,378,094	61.00
62.00	Deductibles billed to program beneficiaries	2,127,440	62.00
63.00	Coinsurance billed to program beneficiaries	52,962	63.00
64.00	Allowable bad debts (see instructions)	756,930	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	492,005	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	589,171	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,689,697	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)	19,656	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	-31,698	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	246,387	70.93
70.94	HRR adjustment amount (see instructions)	-398,494	70.94
70.95	Recovery of accelerated depreciation	0	70.95

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		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)		18,525,548	71.00
71.01	Sequestration adjustment (see instructions)		370,511	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		18,005,919	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)		149,118	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)	976,109	328,945	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.0153733520	1.0141365359	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	15,006	4,650	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9744	0.9796	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-24,988	-6,710	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/18/2018 12:29 pm

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	12,573,999	0	12,573,999		12,573,999	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,753,193	0		3,753,193	3,753,193	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	265,467	0	234,151	31,316	265,467	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	0.0860	0.0860	0.0860	0.0860		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	351,035	0	270,341	80,694	351,035	11.00
11.01	Uncompensated care payments	36.00	815,393	0	815,393	0	815,393	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	17,759,087	0	13,893,884	3,865,203	17,759,087	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	19,499,159	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,064,141	0	15,198,938	3,865,203	19,064,141	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,330,306	0	1,025,688	304,618	1,330,306	16.00
17.00	Special add-on payments for new technologies	54.00	1,750	0	0	1,750	1,750	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/18/2018 12:29 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	16,224,626	4,171,571	20,396,197	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,313,396	0	1,010,088	303,308	1,313,396	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	16,910	0	15,600	1,310	16,910	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	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,330,306	0	1,025,688	304,618	1,330,306	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2018 12:29 pm

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	12,573,999	12,573,999		12,573,999	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,753,193		3,753,193	3,753,193	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	265,467	234,151	31,316	265,467	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	0.0860	0.0860	0.0860		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	351,035	270,341	80,694	351,035	11.00
11.01	Uncompensated care payments	36.00	815,393	607,860	207,533	815,393	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	17,759,087	13,686,351	4,072,736	17,759,087	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	19,499,159	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,064,141	14,991,405	4,072,736	19,064,141	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,330,306	1,025,688	304,618	1,330,306	16.00
17.00	Special add-on payments for new technologies	54.00	1,750	0	1,750	1,750	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			16,017,093	4,379,104	20,396,197	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/18/2018 12:29 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,313,396	1,010,088	303,308	1,313,396	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	16,910	15,600	1,310	16,910	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	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,330,306	1,025,688	304,618	1,330,306	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	246,387	193,305	53,082	246,387	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	19,656	15,006	4,650	19,656	30.01
31.00	HRR adjustment (see instructions)	70.94	-398,494	-321,894	-76,600	-398,494	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-31,698	-24,988	-6,710	-31,698	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: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/18/2018 12:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	67,051	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,031,814	2.00
3.00	OPPS payments	9,347,469	3.00
4.00	Outlier payment (see instructions)	66,119	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)	67,051	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	257,160	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)	257,160	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)	257,160	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	190,109	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)	67,051	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)	9,413,588	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,887,190	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)	7,593,449	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)	7,593,449	30.00
31.00	Primary payer payments	354	31.00
32.00	Subtotal (line 30 minus line 31)	7,593,095	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)	441,576	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	287,024	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	251,480	36.00
37.00	Subtotal (see instructions)	7,880,119	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)	7,880,119	40.00
40.01	Sequestration adjustment (see instructions)	157,602	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	7,490,397	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	232,120	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: 14-0034 Component CCN: 14-S034	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/18/2018 12:29 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	240,254	2.00
3.00	OPPS payments	109,694	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a 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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	109,694	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)	24,930	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)	84,764	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)	84,764	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	84,764	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)	84,764	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)	84,764	40.00
40.01	Sequestration adjustment (see instructions)	1,695	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	83,068	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1	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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

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		18,000,808		7,445,161	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		202,058		64,440	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	07/27/2017	196,947	07/27/2017	19,204	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)		-196,947		-19,204	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)		18,005,919		7,490,397	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		149,118		232,120	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		18,155,037		7,722,517	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: 14-0034 | Component CCN: 14-S034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2018 12:29 pm

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		1,068,619		83,068	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)		1,068,619		83,068	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		72,447		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,141,066		83,069	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: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/18/2018 12:29 pm
	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: 14-0034 Component CCN: 14-S034	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/18/2018 12:29 pm
	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)	1,300,598	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)	13.005479	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)	1,300,598	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)	1,300,598	16.00
17.00	Primary payer payments	1,942	17.00
18.00	Subtotal (line 16 less line 17).	1,298,656	18.00
19.00	Deductibles	194,067	19.00
20.00	Subtotal (line 18 minus line 19)	1,104,589	20.00
21.00	Coinsurance	14,147	21.00
22.00	Subtotal (line 20 minus line 21)	1,090,442	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	113,709	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	73,911	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	98,802	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,164,353	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)	1,164,353	31.00
31.01	Sequestration adjustment (see instructions)	23,287	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,068,619	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)	72,447	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/18/2018 12:29 pm

		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	-12,873,662	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,112,754	0	0	0	4.00
5.00	Other receivable	722,345	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,293,422	0	0	0	7.00
8.00	Prepaid expenses	480,782	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,735,641	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,259,000	0	0	0	12.00
13.00	Land improvements	667,527	0	0	0	13.00
14.00	Accumulated depreciation	-667,527	0	0	0	14.00
15.00	Buildings	36,718,330	0	0	0	15.00
16.00	Accumulated depreciation	-13,536,301	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	4,547,603	0	0	0	19.00
20.00	Accumulated depreciation	-1,663,485	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	23,605,877	0	0	0	23.00
24.00	Accumulated depreciation	-17,239,800	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)	33,691,224	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,303,878	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	1,307,650	137,947	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,611,528	137,947	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,038,393	137,947	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,805,852	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,956,753	0	0	0	38.00
39.00	Payroll taxes payable	108,491	0	0	0	39.00
40.00	Notes and loans payable (short term)	488,415	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	0	0	0	0	43.00
44.00	Other current liabilities	21,851	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,381,362	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	43,841,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	8,469,595	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	52,310,595	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	63,691,957	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-19,653,564				52.00
53.00	Specific purpose fund		137,947			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)	-19,653,564	137,947	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,038,393	137,947	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/18/2018 12:29 pm

		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		-24,241,397		132,112		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11,430,186				2.00
3.00	Total (sum of line 1 and line 2)		-12,811,211		132,112		3.00
4.00	Additions	215,917		958		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00	TRANSFER FROM OTHER FUNDS	8,175		0		0	7.00
8.00		0		0		0	8.00
9.00	DONATIONS	0		7,550		0	9.00
10.00	Total additions (sum of line 4-9)		224,092		8,508		10.00
11.00	Subtotal (line 3 plus line 10)		-12,587,119		140,620		11.00
12.00	Deductions	7,066,445		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00	TRANSFERS TO OTHER FUNDS	0		2,673		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		7,066,445		2,673		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-19,653,564		137,947		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		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00	TRANSFER FROM OTHER FUNDS		0			7.00
8.00			0			8.00
9.00	DONATIONS		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		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00	TRANSFERS TO OTHER FUNDS		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: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/18/2018 12:29 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	15,685,996		15,685,996	1.00
2.00	SUBPROVIDER - IPF	4,461,109		4,461,109	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	20,147,105		20,147,105	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,881,574		3,881,574	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)	3,881,574		3,881,574	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	24,028,679		24,028,679	17.00
18.00	Ancillary services	85,569,870	160,805,166	246,375,036	18.00
19.00	Outpatient services	6,492,250	26,210,167	32,702,417	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OPT	0	0	0	24.20
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NON-REIMBURSABLE PROFESSIONAL FEES	4,765,275	6,825,888	11,591,163	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	120,856,074	193,841,221	314,697,295	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		98,924,780		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)		98,924,780		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0034 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/18/2018 12:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	314,697,295	1.00
2.00	Less contractual allowances and discounts on patients' accounts	207,601,529	2.00
3.00	Net patient revenues (line 1 minus line 2)	107,095,766	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	98,924,780	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,170,986	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	830,242	6.00
7.00	Income from investments	94,514	7.00
8.00	Revenues from telephone and other miscellaneous communication services	4	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	2,547	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	297,690	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	232	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	10,972	21.00
22.00	Rental of hospital space	252,138	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,770,861	24.00
25.00	Total other income (sum of lines 6-24)	3,259,200	25.00
26.00	Total (line 5 plus line 25)	11,430,186	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,430,186	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0034	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/18/2018 12:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,313,396	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	16,910	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)	43.83	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)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,330,306	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