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: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 12:46 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 12:46 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 PASSAVANT AREA HOSPITAL (14-0058) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-108,558	6,978	0	0	1.00
2.00	Subprovider - IPF	0	19	-2		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-1	75		0	7.00
200.00	Total	0	-108,540	7,051	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: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 10:27 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1600 WEST WALNUT	PO Box:			1.00
2.00	City: JACKSONVILLE	State: IL	Zip Code: 62650-1185	County: MORGAN	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	PASSAVANT AREA HOSPITAL	140058	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF	PASSAVANT AREA HOSPITAL	14S058	99914	4	10/01/2016	N	P	N	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	PASSAVANT AREA HOSPITAL	145951	99914		10/31/1997	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	1	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.	1,899	0	0	0	211	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:27 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	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.	1		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.	10/01/2016	09/30/2017	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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)		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.03

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:27 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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

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		1.00	2.00	3.00	
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

		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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? 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	Y	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.	N	N	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.	N	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.	N	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.	N	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.	N	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

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		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

		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:	449,454	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:27 am

		1.00	2.00	
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	14H058	140.00

	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: MEMORIAL HEALTH SYSTEMS	Contractor's Name: MEMORIAL HEALTH SYSTEMS	Contractor's Number: 00131	141.00
142.00	Street: 701 NORTH FIRST STREET	PO Box:		142.00
143.00	City: SPRINGFIELD	State: IL	Zip Code: 62781	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.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0 168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00 169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2016	09/30/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 10:27 am

		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: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 10:27 am

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

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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	01/18/2018	Y	01/18/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 10:27 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00

		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	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.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	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.	N	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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	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.	N	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.	N	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.	Y	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.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 10:27 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR		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: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2018 10:27 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	51	26,040	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)		51	26,040	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	9	3,285	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)		60	29,325	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	15	5,475		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		85				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: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 10:27 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,114	1,327	9,112			1.00
2.00	HMO and other (see instructions)	640	211				2.00
3.00	HMO IPF Subprovider	0	80				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,114	1,327	9,112			7.00
8.00	INTENSIVE CARE UNIT	705	130	1,217			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		442	756			13.00
14.00	Total (see instructions)	5,819	1,899	11,085	0.00	907.53	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	416	1,216	2,769	0.00	30.55	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,768	0	3,852	0.00	28.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	966.08	27.00
28.00	Observation Bed Days		133	609			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			161			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	104			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: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 10:27 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,652	746	3,782	1.00
2.00	HMO and other (see instructions)			190	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,652	746	3,782	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	56	180	427	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2018 10:27 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	41,228,968	0	41,228,968	1,527,068.43	27.00	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		349,092	0	349,092	2,061.40	169.35	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	857,070	0	857,070	38,173.41	22.45	9.00
10.00	Excluded area salaries (see instructions)		1,394,779	0	1,394,779	52,649.84	26.49	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		255,342	0	255,342	4,334.70	58.91	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		131,018	0	131,018	1,047.50	125.08	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		463,977	0	463,977	2,080.00	223.07	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)		15,865,189	0	15,865,189			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		827,847	0	827,847			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		72,553	0	72,553			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)		86,505	0	86,505			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II | Date/Time Prepared: 2/26/2018 10:27 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	338,075	0	338,075	10,693.40	31.62	26.00
27.00	Administrative & General	5.00	7,141,123	0	7,141,123	242,537.05	29.44	27.00
28.00	Administrative & General under contract (see inst.)		27,306	0	27,306	175.50	155.59	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,049,230	0	1,049,230	37,145.99	28.25	30.00
31.00	Laundry & Linen Service	8.00	239,902	0	239,902	17,676.60	13.57	31.00
32.00	Housekeeping	9.00	1,002,366	0	1,002,366	77,443.42	12.94	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,298,939	-850,415	448,524	24,222.36	18.52	34.00
35.00	Dietary under contract (see instructions)		791	0	791	15.25	51.87	35.00
36.00	Cafeteria	11.00	0	850,415	850,415	62,650.61	13.57	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	800,694	0	800,694	23,879.80	33.53	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	948,888	0	948,888	23,890.70	39.72	40.00
41.00	Medical Records & Medical Records Library	16.00	781,809	0	781,809	36,255.50	21.56	41.00
42.00	Social Service	17.00	244,765	0	244,765	7,624.50	32.10	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/26/2018 10:27 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		40,907,973	0	40,907,973	1,525,197.78	26.82	1.00
2.00	Excluded area salaries (see instructions)		2,251,849	0	2,251,849	90,823.25	24.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)		38,656,124	0	38,656,124	1,434,374.53	26.95	3.00
4.00	Subtotal other wages & related costs (see inst.)		850,337	0	850,337	7,462.20	113.95	4.00
5.00	Subtotal wage-related costs (see inst.)		15,951,694	0	15,951,694	0.00	41.27	5.00
6.00	Total (sum of lines 3 thru 5)		55,458,155	0	55,458,155	1,441,836.73	38.46	6.00
7.00	Total overhead cost (see instructions)		13,873,888	0	13,873,888	564,210.68	24.59	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/26/2018 10:27 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,756,977	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	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)	11,376,248	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)	34,237	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)	176,011	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	287,002	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	3,060,014	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	6,197	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	68,904	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	16,765,590	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: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V | Date/Time Prepared: 2/26/2018 10:27 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	255,342	16,765,590	1.00
2.00	Hospital	255,342	16,765,590	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 | Date/Time Prepared: 2/26/2018 10:27 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	13	0	13	13.00
14.00		RUA	10	0	10	14.00
15.00		RVC	118	0	118	15.00
16.00		RVB	185	0	185	16.00
17.00		RVA	375	0	375	17.00
18.00		RHC	331	0	331	18.00
19.00		RHB	279	0	279	19.00
20.00		RHA	1,007	0	1,007	20.00
21.00		RMC	76	0	76	21.00
22.00		RMB	44	0	44	22.00
23.00		RMA	166	0	166	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	9	0	9	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	2	0	2	32.00
33.00		HC2	5	0	5	33.00
34.00		HC1	10	0	10	34.00
35.00		HB2	14	0	14	35.00
36.00		HB1	19	0	19	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	9	0	9	44.00
45.00		CE2	15	0	15	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	6	0	6	49.00
50.00		CC1	13	0	13	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	23	0	23	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	26	0	26	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	4	0	4	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 | Date/Time Prepared: 2/26/2018 10:27 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	4	0	4	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	3	0	3	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	2	0	2	199.00
200.00	TOTAL		2,768	0	2,768	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	857,070	12.87	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	6,657,616			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/26/2018 10:27 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.240136	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,989,729	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	6,461,918	5.00
6.00	Medicaid charges	63,891,880	6.00
7.00	Medicaid cost (line 1 times line 6)	15,342,740	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)	1,891,093	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	55,620	9.00
10.00	Stand-alone CHIP charges	646,985	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	155,364	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	99,744	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)	1,990,837	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)	564,126	129,435	693,561	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	135,467	129,435	264,902	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	7,169	7,169	22.00
23.00	Cost of charity care (line 21 minus line 22)	135,467	122,266	257,733	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)	2,551,259	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	589,714	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	907,252	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,644,007	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	712,323	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	970,056	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,960,893	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,606,597	1,606,597	276,841	1,883,438	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,265,708	2,265,708	48,277	2,313,985	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	338,075	14,616,352	14,954,427	0	14,954,427	4.00
5.01	00540	NONPATIENT TELEPHONES	0	60,876	60,876	0	60,876	5.01
5.02	00550	DATA PROCESSING	963,599	2,216,994	3,180,593	0	3,180,593	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	339,294	181,633	520,927	0	520,927	5.03
5.04	00570	ADMITTING	737,340	35,836	773,176	0	773,176	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	790,683	667,191	1,457,874	0	1,457,874	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	4,310,207	8,310,172	12,620,379	0	12,620,379	5.06
7.00	00700	OPERATION OF PLANT	1,049,230	2,294,061	3,343,291	-137,000	3,206,291	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	239,902	129,100	369,002	0	369,002	8.00
9.00	00900	HOUSEKEEPING	1,002,366	169,541	1,171,907	0	1,171,907	9.00
10.00	01000	DIETARY	1,298,939	1,222,706	2,521,645	-1,650,921	870,724	10.00
11.00	01100	CAFETERIA	0	0	0	1,650,921	1,650,921	11.00
13.00	01300	NURSING ADMINISTRATION	800,694	64,753	865,447	0	865,447	13.00
15.00	01500	PHARMACY	948,888	4,072,712	5,021,600	-3,824,679	1,196,921	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	781,809	90,606	872,415	0	872,415	16.00
17.00	01700	SOCIAL SERVICE	244,765	1,555	246,320	0	246,320	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-19,786	0	-19,786	0	-19,786	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,423,619	3,066,186	7,489,805	-2,289	7,487,516	30.00
31.00	03100	INTENSIVE CARE UNIT	1,363,712	87,771	1,451,483	-189	1,451,294	31.00
40.00	04000	SUBPROVIDER - IPF	1,077,389	81,392	1,158,781	0	1,158,781	40.00
43.00	04300	NURSERY	392,493	47,787	440,280	0	440,280	43.00
44.00	04400	SKILLED NURSING FACILITY	857,070	53,205	910,275	-38	910,237	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,244,935	6,227,027	10,471,962	-2,804,660	7,667,302	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	98,123	11,947	110,070	0	110,070	52.00
53.00	05300	ANESTHESIOLOGY	60,904	497,456	558,360	0	558,360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,886,180	1,443,807	4,329,987	0	4,329,987	54.00
60.00	06000	LABORATORY	1,962,680	2,357,230	4,319,910	0	4,319,910	60.00
65.00	06500	RESPIRATORY THERAPY	1,109,558	293,836	1,403,394	0	1,403,394	65.00
66.00	06600	PHYSICAL THERAPY	3,335,164	421,727	3,756,891	0	3,756,891	66.00
68.00	06800	SPEECH PATHOLOGY	208,602	5,591	214,193	0	214,193	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,182	1,545	7,727	0	7,727	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	130,159	409,590	539,749	0	539,749	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,804,660	2,804,660	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,827,195	3,827,195	73.00
74.00	07400	RENAL DIALYSIS	10,248	94,399	104,647	0	104,647	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	135,486	20,647	156,133	0	156,133	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	68,839	33,954	102,793	0	102,793	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	788,602	892,325	1,680,927	0	1,680,927	90.00
91.00	09100	EMERGENCY	3,925,628	2,789,767	6,715,395	0	6,715,395	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		325,118	325,118	-325,118	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,911,578	57,168,700	98,080,278	-137,000	97,943,278	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	317,988	37,530	355,518	137,000	492,518	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	-598	0	-598	0	-598	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	41,228,968	57,206,230	98,435,198	0	98,435,198	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,232,956	3,116,394		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,439,943	3,753,928		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,824,667	13,129,760		4.00
5.01	00540	NONPATIENT TELEPHONES	-9,809	51,067		5.01
5.02	00550	DATA PROCESSING	0	3,180,593		5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	520,927		5.03
5.04	00570	ADMITTING	0	773,176		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	1,457,874		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	-3,546,536	9,073,843		5.06
7.00	00700	OPERATION OF PLANT	-20,328	3,185,963		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	369,002		8.00
9.00	00900	HOUSEKEEPING	0	1,171,907		9.00
10.00	01000	DIETARY	-62,327	808,397		10.00
11.00	01100	CAFETERIA	-524,268	1,126,653		11.00
13.00	01300	NURSING ADMINISTRATION	-19,271	846,176		13.00
15.00	01500	PHARMACY	0	1,196,921		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-30,214	842,201		16.00
17.00	01700	SOCIAL SERVICE	0	246,320		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19,786	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,719,010	4,768,506		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,451,294		31.00
40.00	04000	SUBPROVIDER - IPF	-20,118	1,138,663		40.00
43.00	04300	NURSERY	0	440,280		43.00
44.00	04400	SKILLED NURSING FACILITY	0	910,237		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-46,580	7,620,722		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	110,070		52.00
53.00	05300	ANESTHESIOLOGY	0	558,360		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,741	4,326,246		54.00
60.00	06000	LABORATORY	-75,000	4,244,910		60.00
65.00	06500	RESPIRATORY THERAPY	-4,990	1,398,404		65.00
66.00	06600	PHYSICAL THERAPY	-90,163	3,666,728		66.00
68.00	06800	SPEECH PATHOLOGY	0	214,193		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,727		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	539,749		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,804,660		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-300	3,826,895		73.00
74.00	07400	RENAL DIALYSIS	-66,522	38,125		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	156,133		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	-1,092	101,701		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-817,341	863,586		90.00
91.00	09100	EMERGENCY	-1,679,846	5,035,549		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,869,438	89,073,840		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	492,518		192.00
192.01	19201	RENTED SPACE	0	0		192.01
194.00	07950	FUND DEVELOPMENT	0	-598		194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,869,438	89,565,760		200.00

RECLASSIFICATIONS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 10:27 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	850,415	800,506		1.00
	0		850,415	800,506		
	B - RECLASS SPOILED DRUGS EXPENSE					
1.00	PHARMACY	15.00	0	2,516		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	2,516		
	C - RECLASS CHARGEABLE DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,827,195		1.00
	0		0	3,827,195		
	D - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	276,841		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	48,277		2.00
	0		0	325,118		
	G - RECLASS REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	137,000		1.00
	0		0	137,000		
	H - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	2,804,660		1.00
	0		0	2,804,660		
500.00	Grand Total: Increases		850,415	7,896,995		500.00

RECLASSIFICATIONS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 10:27 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	850,415	800,506	0		1.00
	0		850,415	800,506			
	B - RECLASS SPOILED DRUGS EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	2,289	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	189	0		2.00
3.00	SKILLED NURSING FACILITY	44.00	0	38	0		3.00
	0		0	2,516			
	C - RECLASS CHARGEABLE DRUG COSTS						
1.00	PHARMACY	15.00	0	3,827,195	0		1.00
	0		0	3,827,195			
	D - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	325,118	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	325,118			
	G - RECLASS REAL ESTATE TAXES						
1.00	OPERATION OF PLANT	7.00	0	137,000	0		1.00
	0		0	137,000			
	H - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	2,804,660	0		1.00
	0		0	2,804,660			
500.00	Grand Total: Decreases		850,415	7,896,995			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2018 10:27 am

		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	242,737	0	0	0	0	1.00
2.00	Land Improvements	3,317,347	50,235	0	50,235	0	2.00
3.00	Buildings and Fixtures	42,159,495	0	0	0	0	3.00
4.00	Building Improvements	5,121,823	0	0	0	0	4.00
5.00	Fixed Equipment	50,240,092	5,946,372	0	5,946,372	0	5.00
6.00	Movable Equipment	40,272,573	5,340,192	0	5,340,192	429,679	6.00
7.00	HIT designated Assets	2,041,819	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	143,395,886	11,336,799	0	11,336,799	429,679	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	143,395,886	11,336,799	0	11,336,799	429,679	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	242,737	0	1.00
2.00	Land Improvements	3,367,582	0	2.00
3.00	Buildings and Fixtures	42,159,495	0	3.00
4.00	Building Improvements	5,121,823	0	4.00
5.00	Fixed Equipment	56,186,464	0	5.00
6.00	Movable Equipment	45,183,086	0	6.00
7.00	HIT designated Assets	2,041,819	0	7.00
8.00	Subtotal (sum of lines 1-7)	154,303,006	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	154,303,006	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2018 10:27 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,606,597	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,265,708	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,872,305	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1,606,597	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,265,708	2.00
3.00	Total (sum of lines 1-2)	0	3,872,305	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 2/26/2018 10:27 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	106,022,574	0	106,022,574	0.696637	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47,224,905	1,055,527	46,169,378	0.303363	0	2.00
3.00	Total (sum of lines 1-2)	153,247,479	1,055,527	152,191,952	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,851,358	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,707,710	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	6,559,068	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	265,036	0	0	0	3,116,394	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,218	0	0	0	3,753,928	2.00
3.00	Total (sum of lines 1-2)	311,254	0	0	0	6,870,322	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 10:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-11,805	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-2,059	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-9,809	NONPATIENT TELEPHONES	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-20,328	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,362,665			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	1,274,667			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-524,268	CAFETERIA	11.00	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	B	-300	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-30,214	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	B	-11,858	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 10:27 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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
33.00	MISCELLANEOUS NURSE ADMIN INCOME	B	-19,271	NURSING ADMINISTRATION	13.00	0	33.00
33.01	MISCELLANEOUS WOC CONTRACTUAL INCOME	B	-14,243	CLINIC	90.00	0	33.01
33.02	TRUST ACCOUNT FEES	A	174,920	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.02
33.03	WEE CARE	B	-1,371	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.03
33.04	CHILDBIRTH PREP	B	-35	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.04
33.05	DOORBELL DINNERS	B	-50,469	DIETARY	10.00	0	33.05
33.06	EDUCATION	B	-25	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.06
33.07	MISC INCOME	B	-9,662	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.07
33.08	EDUCATION INCOME - AHA	B	-15,334	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.08
33.09	MISCELLANEOUS PT INCOME	B	-88,234	PHYSICAL THERAPY	66.00	0	33.09
33.10	RADIATION THERAPY CABLE EXPENSE	A	-340	RADIOLOGY-DIAGNOSTIC	54.00	0	33.10
33.11	INDUSTRIAL REHAB CABLE EXPENSE	A	-1,929	PHYSICAL THERAPY	66.00	0	33.11
33.12	HYPERBARICS CABLE EXPENSE	A	-1,092	HYPERBARIC OXYGEN THERAPY	76.98	0	33.12
33.13	INTERMEDIARY DEPRECIATION ADJUSTMENT	A	30,552	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
33.14	SELF INSURANCE	A	-4,048,575	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	PHYSICIAN RECRUITMENT	A	-105,706	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.15
33.16	PARAMEDIC SALARY EXPENSE	A	-6,353	EMERGENCY	91.00	0	33.16
33.17	PARAMEDIC EMPLOYEE BENEFIT EXPENSE	A	-1,604	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.17
33.18	PARAMEDIC OTHER EXPENSE	A	-2,500	EMERGENCY	91.00	0	33.18
33.19	PARAMEDIC CRC EXPENSE	A	-332	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	CRNA SALARIES	A	19,786	NONPHYSICIAN ANESTHETISTS	19.00	0	33.20
33.21	LOBBYING EXPENSE	A	-24,980	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.21
33.22	COMMUNITY RELATIONS SALARY EXPENSE	A	-215,707	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.22
33.23	COMMUNITY RELATIONS BENEFITS EXPENSE	A	-54,466	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.23
33.24	COMMUNITY RELATIONS OTHER EXPENSE	A	-124,768	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.24
33.25	ALCOHOL EXPENSE	A	-2,151	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.25
33.26	LIFE LINE EXPENSES	A	-57,384	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.26
33.27	REVALUED ASSETS DEPRECIATION ADJUSTM	A	1,164,518	CAP REL COSTS-BLDG & FIXT	1.00	9	33.27
33.28	REVALUED ASSETS DEPRECIATION ADJUSTM	A	1,421,620	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.28
33.30	COMMUNITY BENFIT SALARY EXPENSE	A	-20,485	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.30
33.31	COMMUNITY BENFIT BENEFITS EXPENSE	A	-5,172	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.31
33.32	COMMUNITY BENFIT OTHER EXPENSE	A	-99,739	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.32
33.33	INCOME TAX EXPENSE	A	-5,234	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.33
33.34	PROVIDER TAX	A	-2,410,408	OTHER ADMINISTRATIVE AND GENERAL	5.06	0	33.34
33.35	RETIREE HEALTH INSURANCE PLAN	A	2,405,374	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.35
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,869,438				50.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 10:27 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

(1) 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: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 10:27 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAP BLDG HO	49,691	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAP MME HO MME CAP	20,714	0	2.00
3.00	5.06	OTHER ADMINISTRATIVE AND GEN	HO INTEREST	21,209	0	3.00
4.00	5.06	OTHER ADMINISTRATIVE AND GEN	A&G HO MANAGEMENT	3,356,445	2,173,392	4.00
4.01	0.00			0	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,448,059	2,173,392	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:					

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

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

6.00	B		0.00	MEMORIAL HL SYS	100.00	6.00
7.00	C		0.00	PPA	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/26/2018 10:27 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	49,691	9		1.00
2.00	20,714	9		2.00
3.00	21,209	0		3.00
4.00	1,183,053	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	1,274,667			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	HOME OFFICE		6.00
7.00	PHYSICIAN ORG		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2018 10:27 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.06	OTHER ADMINISTRATIVE AND GENERAL	1,979,695	1,924,202	55,493	211,500	263	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,719,010	2,719,010	0	211,500	0	2.00
3.00	40.00	SUBPROVIDER - IPF	22,210	18,610	3,600	181,300	24	3.00
4.00	50.00	OPERATING ROOM	49,779	46,466	3,313	246,400	27	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	8,630	680	7,950	271,900	40	5.00
6.00	60.00	LABORATORY	75,000	75,000	0	260,300	0	6.00
7.00	65.00	RESPIRATORY THERAPY	6,210	3,510	2,700	211,500	12	7.00
8.00	74.00	RENAL DIALYSIS	70,691	61,600	9,091	211,500	41	8.00
9.00	90.00	CLINIC	803,606	802,481	1,125	211,500	5	9.00
10.00	91.00	EMERGENCY	1,718,739	1,670,993	47,746	211,500	638	10.00
200.00			7,453,570	7,322,552	131,018		1,050	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	5.06	OTHER ADMINISTRATIVE AND GENERAL	26,742	1,337	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	2,092	105	0	0	0	3.00
4.00	50.00	OPERATING ROOM	3,199	160	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	5,229	261	0	0	0	5.00
6.00	60.00	LABORATORY	0	0	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	1,220	61	0	0	0	7.00
8.00	74.00	RENAL DIALYSIS	4,169	208	0	0	0	8.00
9.00	90.00	CLINIC	508	25	0	0	0	9.00
10.00	91.00	EMERGENCY	64,874	3,244	0	0	0	10.00
200.00			108,033	5,401	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	5.06	OTHER ADMINISTRATIVE AND GENERAL	0	26,742	28,751	1,952,953		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,719,010		2.00
3.00	40.00	SUBPROVIDER - IPF	0	2,092	1,508	20,118		3.00
4.00	50.00	OPERATING ROOM	0	3,199	114	46,580		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	5,229	2,721	3,401		5.00
6.00	60.00	LABORATORY	0	0	0	75,000		6.00
7.00	65.00	RESPIRATORY THERAPY	0	1,220	1,480	4,990		7.00
8.00	74.00	RENAL DIALYSIS	0	4,169	4,922	66,522		8.00
9.00	90.00	CLINIC	0	508	617	803,098		9.00
10.00	91.00	EMERGENCY	0	64,874	0	1,670,993		10.00
200.00			0	108,033	40,113	7,362,665		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 10:27 am

		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	NONPATIENT TELEPHONES	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,116,394	3,116,394				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,753,928		3,753,928			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	13,129,760	76,298	47,071	13,253,129		4.00
5.01	00540	NONPATIENT TELEPHONES	51,067	9,456	0	0	60,523	5.01
5.02	00550	DATA PROCESSING	3,180,593	33,856	377,997	313,860	3,137	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	520,927	87,515	0	110,513	595	5.03
5.04	00570	ADMITTING	773,176	11,651	695	240,163	1,677	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,457,874	22,730	0	257,538	1,082	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	9,073,843	251,098	75,217	1,333,644	6,112	5.06
7.00	00700	OPERATION OF PLANT	3,185,963	385,112	58,697	341,751	2,218	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	369,002	64,910	10,308	78,140	216	8.00
9.00	00900	HOUSEKEEPING	1,171,907	122,662	42,585	326,487	325	9.00
10.00	01000	DIETARY	808,397	69,380	46,025	146,091	1,136	10.00
11.00	01100	CAFETERIA	1,126,653	54,334	0	276,994	0	11.00
13.00	01300	NURSING ADMINISTRATION	846,176	15,493	4,290	260,799	1,406	13.00
15.00	01500	PHARMACY	1,196,921	29,934	5,778	309,068	811	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	842,201	40,579	0	254,648	1,028	16.00
17.00	01700	SOCIAL SERVICE	246,320	0	0	79,724	108	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,768,506	335,171	169,410	1,440,844	7,950	30.00
31.00	03100	INTENSIVE CARE UNIT	1,451,294	61,766	40,432	444,183	865	31.00
40.00	04000	SUBPROVIDER - IPF	1,138,663	68,031	38,104	350,923	1,244	40.00
43.00	04300	NURSERY	440,280	8,884	0	127,841	379	43.00
44.00	04400	SKILLED NURSING FACILITY	910,237	77,236	18,556	279,161	1,623	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,620,722	197,531	874,985	1,382,643	6,220	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,070	18,237	0	31,960	108	52.00
53.00	05300	ANESTHESIOLOGY	558,360	11,880	25,912	19,837	1,136	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,326,246	149,875	1,126,852	940,075	3,624	54.00
60.00	06000	LABORATORY	4,244,910	90,304	139,477	639,276	2,109	60.00
65.00	06500	RESPIRATORY THERAPY	1,398,404	43,266	108,219	361,401	1,298	65.00
66.00	06600	PHYSICAL THERAPY	3,666,728	164,613	42,851	1,086,316	2,326	66.00
68.00	06800	SPEECH PATHOLOGY	214,193	3,579	599	67,945	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,727	0	0	2,014	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	539,749	62,314	68,482	42,395	216	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,804,660	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,826,895	2,801	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	38,125	0	22,873	3,338	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	156,133	33,936	10,884	44,130	216	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	101,701	14,544	1,691	22,422	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	863,586	35,948	41,909	256,860	1,460	90.00
91.00	09100	EMERGENCY	5,035,549	237,161	214,505	1,276,571	4,543	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,073,840	2,892,085	3,614,404	13,149,555	55,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,727	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	492,518	1,441	139,524	103,574	1,244	192.00
192.01	19201	RENTED SPACE	0	208,141	0	0	4,111	192.01
194.00	07950	FUND DEVELOPMENT	-598	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,565,760	3,116,394	3,753,928	13,253,129	60,523	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	3,909,443					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	40,339	759,889				5.03
5.04	00570	ADMITTING	201,480	13,943	1,242,785			5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	241,819	48,437	0	2,029,480		5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	604,548	92,831	0	0	11,437,293	5.06
7.00	00700	OPERATION OF PLANT	0	56,789	0	0	4,030,530	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	74,217	0	0	596,793	8.00
9.00	00900	HOUSEKEEPING	0	77,395	0	0	1,741,361	9.00
10.00	01000	DIETARY	120,910	47,002	0	0	1,238,941	10.00
11.00	01100	CAFETERIA	0	82,898	0	0	1,540,879	11.00
13.00	01300	NURSING ADMINISTRATION	403,067	3,165	0	0	1,534,396	13.00
15.00	01500	PHARMACY	80,571	11,249	0	0	1,634,332	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161,248	0	0	0	1,299,704	16.00
17.00	01700	SOCIAL SERVICE	40,339	7,334	0	0	373,825	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,571	14,633	63,728	104,067	6,984,880	30.00
31.00	03100	INTENSIVE CARE UNIT	241,819	3,979	20,509	33,490	2,298,337	31.00
40.00	04000	SUBPROVIDER - IPF	201,480	4,826	12,458	20,344	1,836,073	40.00
43.00	04300	NURSERY	0	1,208	4,459	7,282	590,333	43.00
44.00	04400	SKILLED NURSING FACILITY	80,571	3,567	16,160	26,389	1,413,500	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,339	72,016	196,872	321,489	10,712,817	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	302	4,837	7,899	173,413	52.00
53.00	05300	ANESTHESIOLOGY	0	1,439	30,247	49,393	698,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	201,480	16,513	357,907	584,488	7,707,060	54.00
60.00	06000	LABORATORY	201,480	53,854	141,899	231,718	5,745,027	60.00
65.00	06500	RESPIRATORY THERAPY	120,910	25,767	76,491	124,909	2,260,665	65.00
66.00	06600	PHYSICAL THERAPY	322,496	12,341	75,021	122,508	5,495,200	66.00
68.00	06800	SPEECH PATHOLOGY	0	736	3,324	5,428	295,804	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	469	369	602	11,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,852	21,377	34,908	771,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	27,200	44,418	2,876,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	86,156	140,691	4,056,543	73.00
74.00	07400	RENAL DIALYSIS	0	0	955	1,559	66,850	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,570	2,365	3,862	253,096	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	100	2,252	3,678	146,388	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	7,266	9,594	15,667	1,232,290	90.00
91.00	09100	EMERGENCY	322,496	21,124	88,605	144,691	7,345,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,707,963	758,822	1,242,785	2,029,480	88,398,531	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,727	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	201,480	1,067	0	0	940,848	192.00
192.01	19201	RENTED SPACE	0	0	0	0	212,252	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	-598	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,909,443	759,889	1,242,785	2,029,480	89,565,760	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	11,437,293					5.06
7.00	00700	OPERATION OF PLANT	590,029	4,620,559				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,365	133,972	818,130			8.00
9.00	00900	HOUSEKEEPING	254,918	253,171	4,726	2,254,176		9.00
10.00	01000	DIETARY	181,369	143,199	3,545	0	1,567,054	10.00
11.00	01100	CAFETERIA	225,569	112,143	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	224,620	31,977	0	528,800	0	13.00
15.00	01500	PHARMACY	239,250	61,782	0	46,795	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	190,264	83,753	0	20,128	0	16.00
17.00	01700	SOCIAL SERVICE	54,724	0	0	4,444	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,022,517	691,782	160,217	59,829	886,396	30.00
31.00	03100	INTENSIVE CARE UNIT	336,454	127,482	16,661	51,581	72,837	31.00
40.00	04000	SUBPROVIDER - IPF	268,783	140,415	6,290	0	264,519	40.00
43.00	04300	NURSERY	86,419	18,336	2,801	47,863	0	43.00
44.00	04400	SKILLED NURSING FACILITY	206,922	159,412	77,197	109,187	343,302	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,568,225	407,698	235,573	201,751	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,386	37,641	700	11,966	0	52.00
53.00	05300	ANESTHESIOLOGY	102,210	24,519	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,128,237	309,337	95,323	90,512	0	54.00
60.00	06000	LABORATORY	841,015	186,386	331	65,085	0	60.00
65.00	06500	RESPIRATORY THERAPY	330,939	89,299	4,778	61,282	0	65.00
66.00	06600	PHYSICAL THERAPY	804,442	339,756	41,933	179,572	0	66.00
68.00	06800	SPEECH PATHOLOGY	43,303	7,387	0	33,333	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,637	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	112,910	128,615	0	32,949	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	421,058	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	593,837	5,782	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,786	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	37,051	70,042	117	23,632	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	21,430	30,018	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	180,395	74,196	0	0	0	90.00
91.00	09100	EMERGENCY	1,075,270	489,492	164,168	350,511	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,266,334	4,157,592	814,360	1,919,220	1,567,054	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,156	30,396	0	62,393	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	137,731	2,973	3,770	272,563	0	192.00
192.01	19201	RENTED SPACE	31,072	429,598	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	11,437,293	4,620,559	818,130	2,254,176	1,567,054	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	1,878,591					11.00
13.00	01300	NURSING ADMINISTRATION	41,576	2,361,369				13.00
15.00	01500	PHARMACY	39,807	0	2,021,966			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	50,589	0	0	1,644,438		16.00
17.00	01700	SOCIAL SERVICE	11,109	22,359	0	0	466,461	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	330,324	664,893	0	84,337	240,053	30.00
31.00	03100	INTENSIVE CARE UNIT	81,764	164,574	0	27,141	32,062	31.00
40.00	04000	SUBPROVIDER - IPF	83,180	167,423	0	16,487	72,949	40.00
43.00	04300	NURSERY	26,002	52,327	0	5,902	19,917	43.00
44.00	04400	SKILLED NURSING FACILITY	76,237	153,450	0	21,386	101,480	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	244,612	492,364	27,084	260,536	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,507	13,082	0	6,402	0	52.00
53.00	05300	ANESTHESIOLOGY	5,963	0	63,307	40,028	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	172,895	0	44,258	473,408	0	54.00
60.00	06000	LABORATORY	148,771	0	1,643	187,785	0	60.00
65.00	06500	RESPIRATORY THERAPY	80,376	0	10,804	101,226	0	65.00
66.00	06600	PHYSICAL THERAPY	126,744	0	0	99,281	0	66.00
68.00	06800	SPEECH PATHOLOGY	6,099	0	0	4,399	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	300	0	0	488	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,057	0	289	28,290	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,996	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,866,113	114,017	0	73.00
74.00	07400	RENAL DIALYSIS	300	0	0	1,264	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	6,344	12,744	0	3,129	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	3,267	0	2	2,981	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,854	56,089	2,573	12,697	0	90.00
91.00	09100	EMERGENCY	279,246	562,064	5,888	117,258	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,864,923	2,361,369	2,021,961	1,644,438	466,461	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,668	0	5	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	1,878,591	2,361,369	2,021,966	1,644,438	466,461	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	11,125,228	0	11,125,228		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,208,893	0	3,208,893		31.00
40.00	04000	SUBPROVIDER - IPF	0	2,856,119	0	2,856,119		40.00
43.00	04300	NURSERY	0	849,900	0	849,900		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,662,073	0	2,662,073		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,150,660	0	14,150,660		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	275,097	0	275,097		52.00
53.00	05300	ANESTHESIOLOGY	0	934,231	0	934,231		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,021,030	0	10,021,030		54.00
60.00	06000	LABORATORY	0	7,176,043	0	7,176,043		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,939,369	0	2,939,369		65.00
66.00	06600	PHYSICAL THERAPY	0	7,086,928	0	7,086,928		66.00
68.00	06800	SPEECH PATHOLOGY	0	390,325	0	390,325		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,606	0	13,606		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,089,403	0	1,089,403		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,333,332	0	3,333,332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,636,292	0	6,636,292		73.00
74.00	07400	RENAL DIALYSIS	0	78,200	0	78,200		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	406,155	0	406,155		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	204,086	0	204,086		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,586,094	0	1,586,094		90.00
91.00	09100	EMERGENCY	0	10,389,142	0	10,389,142		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	87,412,206	0	87,412,206		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	109,672	0	109,672		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,371,558	0	1,371,558		192.00
192.01	19201	RENTED SPACE	0	672,922	0	672,922		192.01
194.00	07950	FUND DEVELOPMENT	0	-598	0	-598		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	89,565,760	0	89,565,760		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	76,298	47,071	123,369	123,369	4.00
5.01	00540	NONPATIENT TELEPHONES	0	9,456	0	9,456	0	5.01
5.02	00550	DATA PROCESSING	5,350	33,856	377,997	417,203	2,922	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	87,515	0	87,515	1,029	5.03
5.04	00570	ADMITTING	0	11,651	695	12,346	2,236	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	22,730	0	22,730	2,397	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	0	251,098	75,217	326,315	12,415	5.06
7.00	00700	OPERATION OF PLANT	3,572	385,112	58,697	447,381	3,181	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,910	10,308	75,218	727	8.00
9.00	00900	HOUSEKEEPING	0	122,662	42,585	165,247	3,039	9.00
10.00	01000	DIETARY	0	69,380	46,025	115,405	1,360	10.00
11.00	01100	CAFETERIA	0	54,334	0	54,334	2,578	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,493	4,290	19,783	2,428	13.00
15.00	01500	PHARMACY	3,900	29,934	5,778	39,612	2,877	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,579	0	40,579	2,370	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	742	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,567	335,171	169,410	533,148	13,410	30.00
31.00	03100	INTENSIVE CARE UNIT	16,348	61,766	40,432	118,546	4,135	31.00
40.00	04000	SUBPROVIDER - IPF	0	68,031	38,104	106,135	3,267	40.00
43.00	04300	NURSERY	0	8,884	0	8,884	1,190	43.00
44.00	04400	SKILLED NURSING FACILITY	7,810	77,236	18,556	103,602	2,599	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	33,930	197,531	874,985	1,106,446	12,871	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,237	0	18,237	298	52.00
53.00	05300	ANESTHESIOLOGY	12,803	11,880	25,912	50,595	185	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	149,875	1,126,852	1,276,727	8,751	54.00
60.00	06000	LABORATORY	312	90,304	139,477	230,093	5,951	60.00
65.00	06500	RESPIRATORY THERAPY	2,474	43,266	108,219	153,959	3,364	65.00
66.00	06600	PHYSICAL THERAPY	889	164,613	42,851	208,353	10,112	66.00
68.00	06800	SPEECH PATHOLOGY	0	3,579	599	4,178	632	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	19	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	62,314	68,482	130,796	395	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,801	0	2,801	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	22,873	22,873	31	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	394	33,936	10,884	45,214	411	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	14,544	1,691	16,235	209	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,596	35,948	41,909	79,453	2,391	90.00
91.00	09100	EMERGENCY	15,415	237,161	214,505	467,081	11,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,360	2,892,085	3,614,404	6,639,849	122,405	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,727	0	14,727	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,200	1,441	139,524	142,165	964	192.00
192.01	19201	RENTED SPACE	0	208,141	0	208,141	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	134,560	3,116,394	3,753,928	7,004,882	123,369	202.00

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		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		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
5.01	00540	NONPATIENT TELEPHONES	9,456					5.01
5.02	00550	DATA PROCESSING	490	420,615				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	93	4,340	92,977			5.03
5.04	00570	ADMITTING	262	21,677	1,706	38,227		5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	169	26,017	5,927	0	57,240	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	955	65,042	11,360	0	0	5.06
7.00	00700	OPERATION OF PLANT	346	0	6,948	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34	0	9,081	0	0	8.00
9.00	00900	HOUSEKEEPING	51	0	9,470	0	0	9.00
10.00	01000	DIETARY	177	13,009	5,751	0	0	10.00
11.00	01100	CAFETERIA	0	0	10,143	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	220	43,366	387	0	0	13.00
15.00	01500	PHARMACY	127	8,669	1,376	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161	17,349	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	17	4,340	897	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,242	8,669	1,790	1,960	2,931	30.00
31.00	03100	INTENSIVE CARE UNIT	135	26,017	487	631	943	31.00
40.00	04000	SUBPROVIDER - IPF	194	21,677	590	383	573	40.00
43.00	04300	NURSERY	59	0	148	137	205	43.00
44.00	04400	SKILLED NURSING FACILITY	254	8,669	436	497	743	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	972	4,340	8,812	6,055	9,054	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17	0	37	149	222	52.00
53.00	05300	ANESTHESIOLOGY	177	0	176	930	1,391	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	566	21,677	2,020	11,013	16,545	54.00
60.00	06000	LABORATORY	330	21,677	6,589	4,364	6,526	60.00
65.00	06500	RESPIRATORY THERAPY	203	13,009	3,153	2,353	3,518	65.00
66.00	06600	PHYSICAL THERAPY	363	34,697	1,510	2,307	3,450	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	90	102	153	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	57	11	17	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	34	0	227	657	983	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	837	1,251	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,650	3,962	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	29	44	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34	0	192	73	109	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	12	69	104	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	228	0	889	295	441	90.00
91.00	09100	EMERGENCY	710	34,697	2,585	2,725	4,075	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,620	398,938	92,846	38,227	57,240	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	194	21,677	131	0	0	192.00
192.01	19201	RENTED SPACE	642	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	9,456	420,615	92,977	38,227	57,240	202.00

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		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	416,087					5.06
7.00	00700	OPERATION OF PLANT	21,467	479,323				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,179	13,898	102,137			8.00
9.00	00900	HOUSEKEEPING	9,274	26,263	590	213,934		9.00
10.00	01000	DIETARY	6,599	14,855	443	0	157,599	10.00
11.00	01100	CAFETERIA	8,207	11,633	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	8,172	3,317	0	50,187	0	13.00
15.00	01500	PHARMACY	8,704	6,409	0	4,441	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,922	8,688	0	1,910	0	16.00
17.00	01700	SOCIAL SERVICE	1,991	0	0	422	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,201	71,765	20,002	5,678	89,145	30.00
31.00	03100	INTENSIVE CARE UNIT	12,241	13,225	2,080	4,895	7,325	31.00
40.00	04000	SUBPROVIDER - IPF	9,779	14,566	785	0	26,603	40.00
43.00	04300	NURSERY	3,144	1,902	350	4,542	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,528	16,537	9,637	10,363	34,526	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,029	42,293	29,409	19,147	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	924	3,905	87	1,136	0	52.00
53.00	05300	ANESTHESIOLOGY	3,719	2,544	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,048	32,090	11,900	8,590	0	54.00
60.00	06000	LABORATORY	30,598	19,335	41	6,177	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,040	9,264	597	5,816	0	65.00
66.00	06600	PHYSICAL THERAPY	29,267	35,245	5,235	17,042	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,575	766	0	3,164	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	60	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,108	13,342	0	3,127	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,319	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,605	600	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	356	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,348	7,266	15	2,243	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	780	3,114	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,563	7,697	0	0	0	90.00
91.00	09100	EMERGENCY	39,121	50,778	20,495	33,265	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,868	431,297	101,666	182,145	157,599	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	78	3,153	0	5,921	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,011	308	471	25,868	0	192.00
192.01	19201	RENTED SPACE	1,130	44,565	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	416,087	479,323	102,137	213,934	157,599	202.00

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		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	86,895					11.00
13.00	01300	NURSING ADMINISTRATION	1,923	129,783				13.00
15.00	01500	PHARMACY	1,841	0	74,056			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,340	0	0	80,319		16.00
17.00	01700	SOCIAL SERVICE	514	1,229	0	0	10,152	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,280	36,542	0	4,125	5,224	30.00
31.00	03100	INTENSIVE CARE UNIT	3,782	9,045	0	1,328	698	31.00
40.00	04000	SUBPROVIDER - IPF	3,848	9,202	0	806	1,588	40.00
43.00	04300	NURSERY	1,203	2,876	0	289	433	43.00
44.00	04400	SKILLED NURSING FACILITY	3,526	8,434	0	1,046	2,209	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,315	27,061	992	12,744	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	301	719	0	313	0	52.00
53.00	05300	ANESTHESIOLOGY	276	0	2,319	1,958	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,997	0	1,621	23,037	0	54.00
60.00	06000	LABORATORY	6,881	0	60	9,186	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,718	0	396	4,952	0	65.00
66.00	06600	PHYSICAL THERAPY	5,863	0	0	4,856	0	66.00
68.00	06800	SPEECH PATHOLOGY	282	0	0	215	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14	0	0	24	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	696	0	11	1,384	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,761	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	68,347	5,577	0	73.00
74.00	07400	RENAL DIALYSIS	14	0	0	62	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	293	700	0	153	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	151	0	0	146	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,288	3,083	94	621	0	90.00
91.00	09100	EMERGENCY	12,917	30,892	216	5,736	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,263	129,783	74,056	80,319	10,152	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	632	0	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	86,895	129,783	74,056	80,319	10,152	202.00

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		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		848,112	0	848,112		30.00
31.00	03100	INTENSIVE CARE UNIT		205,513	0	205,513		31.00
40.00	04000	SUBPROVIDER - IPF		199,996	0	199,996		40.00
43.00	04300	NURSERY		25,362	0	25,362		43.00
44.00	04400	SKILLED NURSING FACILITY		210,606	0	210,606		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		1,348,540	0	1,348,540		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		26,345	0	26,345		52.00
53.00	05300	ANESTHESIOLOGY		64,270	0	64,270		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		1,463,582	0	1,463,582		54.00
60.00	06000	LABORATORY		347,808	0	347,808		60.00
65.00	06500	RESPIRATORY THERAPY		216,342	0	216,342		65.00
66.00	06600	PHYSICAL THERAPY		358,300	0	358,300		66.00
68.00	06800	SPEECH PATHOLOGY		11,157	0	11,157		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY		202	0	202		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		155,760	0	155,760		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		19,168	0	19,168		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		105,542	0	105,542		73.00
74.00	07400	RENAL DIALYSIS		23,409	0	23,409		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		58,051	0	58,051		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		20,820	0	20,820		76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		103,043	0	103,043		90.00
91.00	09100	EMERGENCY		717,176	0	717,176		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,529,104	0	6,529,104		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		23,879	0	23,879		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		197,421	0	197,421		192.00
192.01	19201	RENTED SPACE		254,478	0	254,478		192.01
194.00	07950	FUND DEVELOPMENT		0	0	0		194.00
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,004,882	0	7,004,882		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (DEPT TIME)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	272,559					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,150,272				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,673	39,502	40,689,217			4.00
5.01	00540	NONPATIENT TELEPHONES	827	0	0	1,119		5.01
5.02	00550	DATA PROCESSING	2,961	317,213	963,599	58	36,731	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	7,654	0	339,294	11	379	5.03
5.04	00570	ADMITTING	1,019	583	737,340	31	1,893	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,988	0	790,683	20	2,272	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	21,961	63,122	4,094,500	113	5,680	5.06
7.00	00700	OPERATION OF PLANT	33,682	49,258	1,049,230	41	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,677	8,650	239,902	4	0	8.00
9.00	00900	HOUSEKEEPING	10,728	35,737	1,002,366	6	0	9.00
10.00	01000	DIETARY	6,068	38,624	448,524	21	1,136	10.00
11.00	01100	CAFETERIA	4,752	0	850,415	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,355	3,600	800,694	26	3,787	13.00
15.00	01500	PHARMACY	2,618	4,849	948,888	15	757	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,549	0	781,809	19	1,515	16.00
17.00	01700	SOCIAL SERVICE	0	0	244,765	2	379	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,314	142,168	4,423,619	147	757	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	33,930	1,363,712	16	2,272	31.00
40.00	04000	SUBPROVIDER - IPF	5,950	31,977	1,077,389	23	1,893	40.00
43.00	04300	NURSERY	777	0	392,493	7	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	15,572	857,070	30	757	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,276	734,282	4,244,935	115	379	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	0	98,123	2	0	52.00
53.00	05300	ANESTHESIOLOGY	1,039	21,745	60,904	21	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,108	945,645	2,886,180	67	1,893	54.00
60.00	06000	LABORATORY	7,898	117,048	1,962,680	39	1,893	60.00
65.00	06500	RESPIRATORY THERAPY	3,784	90,817	1,109,558	24	1,136	65.00
66.00	06600	PHYSICAL THERAPY	14,397	35,960	3,335,164	43	3,030	66.00
68.00	06800	SPEECH PATHOLOGY	313	503	208,602	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	6,182	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,450	57,470	130,159	4	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	19,195	10,248	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	9,134	135,486	4	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	1,419	68,839	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,144	35,170	788,602	27	0	90.00
91.00	09100	EMERGENCY	20,742	180,011	3,919,275	84	3,030	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	252,941	3,033,184	40,371,229	1,020	34,838	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	117,088	317,988	23	1,893	192.00
192.01	19201	RENTED SPACE	18,204	0	0	76	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	3,116,394	3,753,928	13,253,129	60,523	3,909,443	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.433833	1.191620	0.325716	54.086685	106.434429	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			123,369	9,456	420,615	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003032	8.450402	11.451226	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	PURCHASING RECEIVING AND STORES (COST OF SUPPLIES)	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,148,376					5.03
5.04	00570	ADMITTING	21,071	364,010,728				5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	73,200	0	364,010,728			5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	140,290	0	0	-11,437,293	78,129,065	5.06
7.00	00700	OPERATION OF PLANT	85,822	0	0	0	4,030,530	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	112,160	0	0	0	596,793	8.00
9.00	00900	HOUSEKEEPING	116,962	0	0	0	1,741,361	9.00
10.00	01000	DIETARY	71,032	0	0	0	1,238,941	10.00
11.00	01100	CAFETERIA	125,279	0	0	0	1,540,879	11.00
13.00	01300	NURSING ADMINISTRATION	4,783	0	0	0	1,534,396	13.00
15.00	01500	PHARMACY	17,000	0	0	0	1,634,332	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,299,704	16.00
17.00	01700	SOCIAL SERVICE	11,084	0	0	0	373,825	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,114	18,666,780	18,666,780	0	6,984,880	30.00
31.00	03100	INTENSIVE CARE UNIT	6,013	6,007,252	6,007,252	0	2,298,337	31.00
40.00	04000	SUBPROVIDER - IPF	7,293	3,649,139	3,649,139	0	1,836,073	40.00
43.00	04300	NURSERY	1,825	1,306,239	1,306,239	0	590,333	43.00
44.00	04400	SKILLED NURSING FACILITY	5,390	4,733,400	4,733,400	0	1,413,500	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	108,834	57,666,183	57,666,183	0	10,712,817	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	456	1,416,898	1,416,898	0	173,413	52.00
53.00	05300	ANESTHESIOLOGY	2,174	8,859,741	8,859,741	0	698,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,955	104,819,231	104,819,231	0	7,707,060	54.00
60.00	06000	LABORATORY	81,386	41,563,841	41,563,841	0	5,745,027	60.00
65.00	06500	RESPIRATORY THERAPY	38,940	22,405,156	22,405,156	0	2,260,665	65.00
66.00	06600	PHYSICAL THERAPY	18,651	21,974,574	21,974,574	0	5,495,200	66.00
68.00	06800	SPEECH PATHOLOGY	1,113	973,556	973,556	0	295,804	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	709	107,994	107,994	0	11,181	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,799	6,261,515	6,261,515	0	771,293	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,967,315	7,967,315	0	2,876,278	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	25,236,141	25,236,141	0	4,056,543	73.00
74.00	07400	RENAL DIALYSIS	0	279,676	279,676	0	66,850	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,373	692,661	692,661	0	253,096	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	151	659,703	659,703	0	146,388	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,981	2,810,224	2,810,224	0	1,232,290	90.00
91.00	09100	EMERGENCY	31,924	25,953,509	25,953,509	0	7,345,245	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,146,764	364,010,728	364,010,728	-11,437,293	76,961,238	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,727	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,612	0	0	0	940,848	192.00
192.01	19201	RENTED SPACE	0	0	0	0	212,252	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	598	0	194.00
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)	759,889	1,242,785	2,029,480		11,437,293	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.661707	0.003414	0.005575		0.146390	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,977	38,227	57,240		416,087	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.080964	0.000105	0.000157		0.005326	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 10:27 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
7.00	00700	OPERATION OF PLANT	195,794					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,677	1,059,543				8.00
9.00	00900	HOUSEKEEPING	10,728	6,120	52,748			9.00
10.00	01000	DIETARY	6,068	4,591	0	51,398		10.00
11.00	01100	CAFETERIA	4,752	0	0	0	68,996	11.00
13.00	01300	NURSING ADMINISTRATION	1,355	0	12,374	0	1,527	13.00
15.00	01500	PHARMACY	2,618	0	1,095	0	1,462	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,549	0	471	0	1,858	16.00
17.00	01700	SOCIAL SERVICE	0	0	104	0	408	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,314	207,493	1,400	29,073	12,132	30.00
31.00	03100	INTENSIVE CARE UNIT	5,402	21,577	1,207	2,389	3,003	31.00
40.00	04000	SUBPROVIDER - IPF	5,950	8,146	0	8,676	3,055	40.00
43.00	04300	NURSERY	777	3,628	1,120	0	955	43.00
44.00	04400	SKILLED NURSING FACILITY	6,755	99,976	2,555	11,260	2,800	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,276	305,086	4,721	0	8,984	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,595	907	280	0	239	52.00
53.00	05300	ANESTHESIOLOGY	1,039	0	0	0	219	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,108	123,451	2,118	0	6,350	54.00
60.00	06000	LABORATORY	7,898	429	1,523	0	5,464	60.00
65.00	06500	RESPIRATORY THERAPY	3,784	6,188	1,434	0	2,952	65.00
66.00	06600	PHYSICAL THERAPY	14,397	54,306	4,202	0	4,655	66.00
68.00	06800	SPEECH PATHOLOGY	313	0	780	0	224	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,450	0	771	0	553	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	11	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,968	152	553	0	233	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	1,272	0	0	0	120	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,144	0	0	0	1,023	90.00
91.00	09100	EMERGENCY	20,742	212,610	8,202	0	10,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	176,176	1,054,660	44,910	51,398	68,494	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,288	0	1,460	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	126	4,883	6,378	0	502	192.00
192.01	19201	RENTED SPACE	18,204	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
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)	4,620,559	818,130	2,254,176	1,567,054	1,878,591	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.599084	0.772154	42.734815	30.488618	27.227535	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	479,323	102,137	213,934	157,599	86,895	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.448099	0.096397	4.055775	3.066248	1.259421	205.00

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		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			13.00	15.00	16.00	17.00	19.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING RECEIVING AND STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL						5.06
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	896,226					13.00
15.00	01500	PHARMACY	0	4,146,833				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	364,010,728			16.00
17.00	01700	SOCIAL SERVICE	8,486	0	0	17,706		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	252,351	0	18,666,780	9,112	0	30.00
31.00	03100	INTENSIVE CARE UNIT	62,462	0	6,007,252	1,217	0	31.00
40.00	04000	SUBPROVIDER - IPF	63,543	0	3,649,139	2,769	0	40.00
43.00	04300	NURSERY	19,860	0	1,306,239	756	0	43.00
44.00	04400	SKILLED NURSING FACILITY	58,240	0	4,733,400	3,852	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	186,870	55,547	57,666,183	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,965	0	1,416,898	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	129,836	8,859,741	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	90,769	104,819,231	0	0	54.00
60.00	06000	LABORATORY	0	3,369	41,563,841	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,158	22,405,156	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	21,974,574	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	973,556	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	107,994	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	593	6,261,515	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	7,967,315	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,827,195	25,236,141	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	279,676	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	4,837	0	692,661	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	4	659,703	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	21,288	5,276	2,810,224	0	0	90.00
91.00	09100	EMERGENCY	213,324	12,075	25,953,509	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	896,226	4,146,822	364,010,728	17,706	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	11	0	0	0	192.00
192.01	19201	RENTED SPACE	0	0	0	0	0	192.01
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,361,369	2,021,966	1,644,438	466,461	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.634792	0.487593	0.004518	26.344798	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	129,783	74,056	80,319	10,152	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.144811	0.017858	0.000221	0.573365	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:27 am

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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	11,125,228		11,125,228	0	11,125,228	30.00
31.00	03100	INTENSIVE CARE UNIT	3,208,893		3,208,893	0	3,208,893	31.00
40.00	04000	SUBPROVIDER - IPF	2,856,119		2,856,119	1,508	2,857,627	40.00
43.00	04300	NURSERY	849,900		849,900	0	849,900	43.00
44.00	04400	SKILLED NURSING FACILITY	2,662,073		2,662,073	0	2,662,073	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,150,660		14,150,660	114	14,150,774	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	275,097		275,097	0	275,097	52.00
53.00	05300	ANESTHESIOLOGY	934,231		934,231	0	934,231	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,021,030		10,021,030	2,721	10,023,751	54.00
60.00	06000	LABORATORY	7,176,043		7,176,043	0	7,176,043	60.00
65.00	06500	RESPIRATORY THERAPY	2,939,369	0	2,939,369	1,480	2,940,849	65.00
66.00	06600	PHYSICAL THERAPY	7,086,928	0	7,086,928	0	7,086,928	66.00
68.00	06800	SPEECH PATHOLOGY	390,325	0	390,325	0	390,325	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,606		13,606	0	13,606	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,089,403		1,089,403	0	1,089,403	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,333,332		3,333,332	0	3,333,332	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,636,292		6,636,292	0	6,636,292	73.00
74.00	07400	RENAL DIALYSIS	78,200		78,200	4,922	83,122	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	406,155		406,155	0	406,155	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	204,086		204,086	0	204,086	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,586,094		1,586,094	617	1,586,711	90.00
91.00	09100	EMERGENCY	10,389,142		10,389,142	0	10,389,142	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	696,970		696,970		696,970	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	88,109,176	0	88,109,176	11,362	88,120,538	200.00
201.00		Less Observation Beds	696,970		696,970		696,970	201.00
202.00		Total (see instructions)	87,412,206	0	87,412,206	11,362	87,423,568	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:27 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,800,641		17,800,641			30.00
31.00	03100	INTENSIVE CARE UNIT	6,007,252		6,007,252			31.00
40.00	04000	SUBPROVIDER - IPF	3,649,139		3,649,139			40.00
43.00	04300	NURSERY	1,306,239		1,306,239			43.00
44.00	04400	SKILLED NURSING FACILITY	4,733,400		4,733,400			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,996,762	39,669,421	57,666,183	0.245389	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,095,829	321,069	1,416,898	0.194154	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,879,315	5,980,426	8,859,741	0.105447	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,561,162	95,258,069	104,819,231	0.095603	0.000000	54.00
60.00	06000	LABORATORY	14,148,040	27,415,801	41,563,841	0.172651	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	10,631,945	11,773,211	22,405,156	0.131192	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,079,271	16,895,303	21,974,574	0.322506	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	233,904	739,652	973,556	0.400927	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	9,333	98,661	107,994	0.125988	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,849,113	2,412,402	6,261,515	0.173984	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,893,090	2,074,225	7,967,315	0.418376	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,936,444	13,299,697	25,236,141	0.262968	0.000000	73.00
74.00	07400	RENAL DIALYSIS	279,676	0	279,676	0.279609	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	692,661	692,661	0.586369	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	659,703	659,703	0.309360	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	112,779	2,697,445	2,810,224	0.564401	0.000000	90.00
91.00	09100	EMERGENCY	3,925,685	22,027,824	25,953,509	0.400298	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	127,144	738,995	866,139	0.804686	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	121,256,163	242,754,565	364,010,728			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	121,256,163	242,754,565	364,010,728			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 10:27 am

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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
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.245391		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.194154		52.00
53.00	05300	ANESTHESIOLOGY	0.105447		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095629		54.00
60.00	06000	LABORATORY	0.172651		60.00
65.00	06500	RESPIRATORY THERAPY	0.131258		65.00
66.00	06600	PHYSICAL THERAPY	0.322506		66.00
68.00	06800	SPEECH PATHOLOGY	0.400927		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125988		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418376		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262968		73.00
74.00	07400	RENAL DIALYSIS	0.297208		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.586369		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309360		76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.564621		90.00
91.00	09100	EMERGENCY	0.400298		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804686		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	848,112	0	848,112	9,721	87.25	30.00
31.00	INTENSIVE CARE UNIT	205,513		205,513	1,217	168.87	31.00
40.00	SUBPROVIDER - IPF	199,996	0	199,996	2,769	72.23	40.00
43.00	NURSERY	25,362		25,362	756	33.55	43.00
44.00	SKILLED NURSING FACILITY	210,606		210,606	3,852	54.67	44.00
200.00	Total (lines 30 through 199)	1,489,589		1,489,589	18,315		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,114	446,197	30.00
31.00	INTENSIVE CARE UNIT	705	119,053	31.00
40.00	SUBPROVIDER - IPF	416	30,048	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	2,768	151,327	44.00
200.00	Total (lines 30 through 199)	9,003	746,625	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 10:27 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,348,540	57,666,183	0.023385	7,765,091	181,587	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,345	1,416,898	0.018593	15,978	297	52.00
53.00	05300	ANESTHESIOLOGY	64,270	8,859,741	0.007254	1,352,539	9,811	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,463,582	104,819,231	0.013963	7,820,874	109,203	54.00
60.00	06000	LABORATORY	347,808	41,563,841	0.008368	7,926,656	66,330	60.00
65.00	06500	RESPIRATORY THERAPY	216,342	22,405,156	0.009656	6,782,706	65,494	65.00
66.00	06600	PHYSICAL THERAPY	358,300	21,974,574	0.016305	1,663,348	27,121	66.00
68.00	06800	SPEECH PATHOLOGY	11,157	973,556	0.011460	135,964	1,558	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	202	107,994	0.001870	6,666	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	155,760	6,261,515	0.024876	2,019,560	50,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,168	7,967,315	0.002406	3,154,922	7,591	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,542	25,236,141	0.004182	5,458,602	22,828	73.00
74.00	07400	RENAL DIALYSIS	23,409	279,676	0.083700	197,976	16,571	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	58,051	692,661	0.083809	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	20,820	659,703	0.031560	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	103,043	2,810,224	0.036667	67,547	2,477	90.00
91.00	09100	EMERGENCY	717,176	25,953,509	0.027633	2,262,099	62,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	53,132	866,139	0.061344	56,391	3,459	92.00
200.00		Total (lines 50 through 199)	5,092,647	330,514,057		46,686,919	627,087	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/26/2018 10:27 am

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	9,721	0.00	5,114	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,217	0.00	705	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,769	0.00	416	40.00
43.00	04300	NURSERY		0	756	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	3,852	0.00	2,768	44.00
200.00		Total (lines 30 through 199)		0	18,315		9,003	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:27 am

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		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
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:27 am

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		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	57,666,183	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,416,898	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,859,741	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	104,819,231	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	41,563,841	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,405,156	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,974,574	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	973,556	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	107,994	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,261,515	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,967,315	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,236,141	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	279,676	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	692,661	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	659,703	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,810,224	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,953,509	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	866,139	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	330,514,057		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	7,765,091	0	11,447,916	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	15,978	0	7,490	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,352,539	0	1,424,131	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	7,820,874	0	30,273,037	0	54.00
60.00	06000	LABORATORY	0.000000	7,926,656	0	6,068,434	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,782,706	0	3,636,998	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,663,348	0	48,347	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	135,964	0	1,418	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	6,666	0	11,999	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,019,560	0	762,645	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,154,922	0	572,370	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,458,602	0	4,635,136	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	197,976	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	370,975	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	348,793	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	67,547	0	1,215,539	0	90.00
91.00	09100	EMERGENCY	0.000000	2,262,099	0	5,723,429	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	56,391	0	267,572	0	92.00
200.00		Total (lines 50 through 199)		46,686,919	0	66,816,229	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.245389	11,447,916	16	0	2,809,193	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.194154	7,490	0	0	1,454	52.00
53.00	05300	ANESTHESIOLOGY	0.105447	1,424,131	0	0	150,170	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095603	30,273,037	0	4,299	2,894,193	54.00
60.00	06000	LABORATORY	0.172651	6,068,434	394	0	1,047,721	60.00
65.00	06500	RESPIRATORY THERAPY	0.131192	3,636,998	0	0	477,145	65.00
66.00	06600	PHYSICAL THERAPY	0.322506	48,347	59	0	15,592	66.00
68.00	06800	SPEECH PATHOLOGY	0.400927	1,418	0	0	569	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125988	11,999	0	0	1,512	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	762,645	114	0	132,688	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418376	572,370	0	0	239,466	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262968	4,635,136	0	78,631	1,218,892	73.00
74.00	07400	RENAL DIALYSIS	0.279609	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.586369	370,975	0	0	217,528	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309360	348,793	0	0	107,903	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.564401	1,215,539	15	1,414	686,051	90.00
91.00	09100	EMERGENCY	0.400298	5,723,429	43	43	2,291,077	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804686	267,572	0	0	215,311	92.00
200.00		Subtotal (see instructions)		66,816,229	641	84,387	12,506,465	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		66,816,229	641	84,387	12,506,465	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	4	0		50.00
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	411		54.00
60.00	06000	LABORATORY	68	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	19	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,677		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	8	798		90.00
91.00	09100	EMERGENCY	17	17		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	136	21,903		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	136	21,903		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,348,540	57,666,183	0.023385	214	5	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	26,345	1,416,898	0.018593	0	0	52.00
53.00	05300	ANESTHESIOLOGY	64,270	8,859,741	0.007254	2,113	15	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,463,582	104,819,231	0.013963	8,703	122	54.00
60.00	06000	LABORATORY	347,808	41,563,841	0.008368	84,168	704	60.00
65.00	06500	RESPIRATORY THERAPY	216,342	22,405,156	0.009656	19,087	184	65.00
66.00	06600	PHYSICAL THERAPY	358,300	21,974,574	0.016305	35,120	573	66.00
68.00	06800	SPEECH PATHOLOGY	11,157	973,556	0.011460	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	202	107,994	0.001870	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	155,760	6,261,515	0.024876	467	12	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,168	7,967,315	0.002406	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	105,542	25,236,141	0.004182	82,278	344	73.00
74.00	07400	RENAL DIALYSIS	23,409	279,676	0.083700	1	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	58,051	692,661	0.083809	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	20,820	659,703	0.031560	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	103,043	2,810,224	0.036667	21	1	90.00
91.00	09100	EMERGENCY	717,176	25,953,509	0.027633	25,186	696	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	866,139	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,039,515	330,514,057		257,358	2,656	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058
Component CCN: 14-S058
Period: From 10/01/2016 To 09/30/2017
Worksheet D Part IV
Date/Time Prepared: 2/26/2018 10:27 am
Title XVIII
Subprovider - IPF
PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	57,666,183	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,416,898	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,859,741	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	104,819,231	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	41,563,841	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,405,156	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,974,574	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	973,556	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	107,994	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,261,515	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,967,315	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,236,141	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	279,676	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	692,661	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	659,703	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,810,224	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,953,509	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	866,139	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	330,514,057		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	214	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,113	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	8,703	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	84,168	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	19,087	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	35,120	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	467	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	82,278	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	21	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	25,186	0	532	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		257,358	0	532	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.245389	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.194154	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105447	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095603	0	0	315	0	54.00
60.00	06000	LABORATORY	0.172651	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.131192	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322506	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.400927	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125988	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418376	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262968	0	0	5,768	0	73.00
74.00	07400	RENAL DIALYSIS	0.279609	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.586369	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309360	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.564401	0	0	104	0	90.00
91.00	09100	EMERGENCY	0.400298	532	0	0	213	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804686	0	0	0	0	92.00
200.00		Subtotal (see instructions)		532	0	6,187	213	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		532	0	6,187	213	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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	30		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,517		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	59		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	1,606		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	1,606		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058
Component CCN: 14-5951

Period:
From 10/01/2016
To 09/30/2017

Worksheet D
Part IV
Date/Time Prepared:
2/26/2018 10:27 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	57,666,183	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,416,898	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,859,741	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	104,819,231	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	41,563,841	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	22,405,156	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,974,574	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	973,556	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	107,994	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,261,515	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,967,315	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	25,236,141	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	279,676	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	692,661	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	659,703	0.000000	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	2,810,224	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	25,953,509	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	866,139	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	330,514,057		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	31,999	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	35,402	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	91,084	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	584,262	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,091,018	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,649,016	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	49,278	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	102,556	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	665,407	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	427	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	12,095	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	3,949	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,316,493	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Skilled Nursing Facility | 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	0.245389	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.194154	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105447	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095603	0	0	131	0	54.00
60.00	06000	LABORATORY	0.172651	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.131192	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.322506	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.400927	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125988	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418376	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262968	0	0	2,403	0	73.00
74.00	07400	RENAL DIALYSIS	0.279609	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.586369	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309360	0	0	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.564401	0	0	43	0	90.00
91.00	09100	EMERGENCY	0.400298	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804686	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	2,577	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	2,577	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Skilled Nursing Facility | 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
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	13	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	632	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	24	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	669	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	669	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,721	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,721	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)	9,112	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,114	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)	11,125,228	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)	11,125,228	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)	11,125,228	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)	1,144.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,852,717	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	5,852,717	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,208,893	1,217	2,636.72	705	1,858,888	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)	9,804,351	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	17,515,956	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)	565,250	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	627,087	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,192,337	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16,323,619	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)	609	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,144.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	696,970	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	848,112	11,125,228	0.076233	696,970	53,132	90.00
91.00	Nursing School cost	0	11,125,228	0.000000	696,970	0	91.00
92.00	Allied health cost	0	11,125,228	0.000000	696,970	0	92.00
93.00	All other Medical Education	0	11,125,228	0.000000	696,970	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,769	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,769	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)	2,769	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)	416	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,857,627	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,857,627	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,857,627	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)	1,032.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	429,316	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)	429,316	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	61,282	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	490,598	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)	30,048	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,656	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	32,704	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	457,894	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: 14-0058 Component CCN: 14-S058	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	199,996	2,857,627	0.069987	0	0	90.00
91.00	Nursing School cost	0	2,857,627	0.000000	0	0	91.00
92.00	Allied health cost	0	2,857,627	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,857,627	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,852	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,852	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,852	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)	2,768	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,662,073	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,662,073	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,662,073	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0058 | Component CCN: 14-5951 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,662,073	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	691.09	71.00
72.00	Program routine service cost (line 9 x line 71)	1,912,937	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	1,912,937	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	1,912,937	83.00
84.00	Program inpatient ancillary services (see instructions)	1,017,224	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	2,930,161	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: 14-0058 Component CCN: 14-5951	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,089,246		30.00
31.00	03100	INTENSIVE CARE UNIT		3,489,560		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245391	7,765,091	1,905,483	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.194154	15,978	3,102	52.00
53.00	05300	ANESTHESIOLOGY	0.105447	1,352,539	142,621	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095629	7,820,874	747,902	54.00
60.00	06000	LABORATORY	0.172651	7,926,656	1,368,545	60.00
65.00	06500	RESPIRATORY THERAPY	0.131258	6,782,706	890,284	65.00
66.00	06600	PHYSICAL THERAPY	0.322506	1,663,348	536,440	66.00
68.00	06800	SPEECH PATHOLOGY	0.400927	135,964	54,512	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125988	6,666	840	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	2,019,560	351,371	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418376	3,154,922	1,319,944	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262968	5,458,602	1,435,438	73.00
74.00	07400	RENAL DIALYSIS	0.297208	197,976	58,840	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.586369	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309360	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.564621	67,547	38,138	90.00
91.00	09100	EMERGENCY	0.400298	2,262,099	905,514	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804686	56,391	45,377	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		46,686,919	9,804,351	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)		46,686,919		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		544,006		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245391	214	53	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.194154	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105447	2,113	223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095629	8,703	832	54.00
60.00	06000	LABORATORY	0.172651	84,168	14,532	60.00
65.00	06500	RESPIRATORY THERAPY	0.131258	19,087	2,505	65.00
66.00	06600	PHYSICAL THERAPY	0.322506	35,120	11,326	66.00
68.00	06800	SPEECH PATHOLOGY	0.400927	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125988	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	467	81	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262968	82,278	21,636	73.00
74.00	07400	RENAL DIALYSIS	0.297208	1	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.586369	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309360	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.564621	21	12	90.00
91.00	09100	EMERGENCY	0.400298	25,186	10,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804686	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		257,358	61,282	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)		257,358		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3

Component CCN: 14-5951 | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.245389	31,999	7,852	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.194154	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.105447	35,402	3,733	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.095603	91,084	8,708	54.00
60.00	06000	LABORATORY	0.172651	584,262	100,873	60.00
65.00	06500	RESPIRATORY THERAPY	0.131192	1,091,018	143,133	65.00
66.00	06600	PHYSICAL THERAPY	0.322506	1,649,016	531,818	66.00
68.00	06800	SPEECH PATHOLOGY	0.400927	49,278	19,757	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.125988	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.173984	102,556	17,843	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.418376	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.262968	665,407	174,981	73.00
74.00	07400	RENAL DIALYSIS	0.279609	427	119	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.586369	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.309360	0	0	76.98
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.564401	12,095	6,826	90.00
91.00	09100	EMERGENCY	0.400298	3,949	1,581	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.804686	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,316,493	1,017,224	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)		4,316,493		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	11,524,881	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)	436,522	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)	78.67	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)	5.10	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.59	31.00
32.00	Sum of lines 30 and 31	23.69	32.00
33.00	Allowable disproportionate share percentage (see instructions)	8.76	33.00
34.00	Disproportionate share adjustment (see instructions)	252,395	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000046425	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	277,505	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	277,505	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	277,505		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

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	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	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	12,491,303		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	15,294,656		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	15,294,656	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	972,830	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	16,267,486	59.00
60.00	Primary payer payments	0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	16,267,486	61.00
62.00	Deductibles billed to program beneficiaries	1,564,248	62.00
63.00	Coinsurance billed to program beneficiaries	19,054	63.00
64.00	Allowable bad debts (see instructions)	400,420	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	260,273	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	362,935	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	14,944,457	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)	0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	55,641	70.93
70.94	HRR adjustment amount (see instructions)	-54,169	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		14,945,929	71.00
71.01	Sequestration adjustment (see instructions)		298,919	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		14,755,568	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)		-108,558	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	22,039	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,506,465	2.00
3.00	OPPS payments	10,015,242	3.00
4.00	Outlier payment (see instructions)	8,529	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)	22,039	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	85,028	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)	85,028	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)	85,028	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	62,989	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 (line 11 minus line 20) (see instructions)	22,039	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	10,023,771	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)	2,095,727	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)	7,950,083	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)	7,950,083	30.00
31.00	Primary payer payments	54	31.00
32.00	Subtotal (line 30 minus line 31)	7,950,029	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)	506,832	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	329,441	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	455,461	36.00
37.00	Subtotal (see instructions)	8,279,470	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	8,279,470	40.00
40.01	Sequestration adjustment (see instructions)	165,589	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	8,106,903	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	6,978	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: 14-0058 Component CCN: 14-S058	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,606	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	213	2.00
3.00	OPPS payments	238	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)	1,606	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	6,187	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)	6,187	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)	6,187	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	4,581	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 (line 11 minus line 20) (see instructions)	1,606	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)	238	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,844	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,844	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,844	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,844	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,844	40.00
40.01	Sequestration adjustment (see instructions)	37	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	1,809	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2	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: 14-0058 Component CCN: 14-5951	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	669	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	669	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,577	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)	2,577	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)	2,577	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	1,908	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 (line 11 minus line 20) (see instructions)	669	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)	0	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)		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)	669	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)	669	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	669	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)	669	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	669	40.00
40.01	Sequestration adjustment (see instructions)	13	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	581	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	75	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		14,929,638		8,147,677	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	05/11/2017	174,070	05/11/2017	40,774	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)		-174,070		-40,774	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)		14,755,568		8,106,903	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		6,978	6.01
6.02	SETTLEMENT TO PROGRAM		108,558		0	6.02
7.00	Total Medicare program liability (see instructions)		14,647,010		8,113,881	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: 14-0058 | Component CCN: 14-S058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 10:27 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		291,386		1,809	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)		291,386		1,809	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		19		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2	6.02
7.00	Total Medicare program liability (see instructions)		291,405		1,807	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: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part I Date/Time Prepared: 2/26/2018 10:27 am
Component CCN: 14-5951		
Title XVIII	Skilled Nursing Facility	PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		955,456		581	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)		955,456		581	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		75	6.01
6.02	SETTLEMENT TO PROGRAM		1		0	6.02
7.00	Total Medicare program liability (see instructions)		955,455		656	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: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058 Component CCN: 14-S058	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part II Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	361,857	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)	7.586301	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)	361,857	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)	361,857	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	361,857	18.00
19.00	Deductibles	60,312	19.00
20.00	Subtotal (line 18 minus line 19)	301,545	20.00
21.00	Coinsurance	4,193	21.00
22.00	Subtotal (line 20 minus line 21)	297,352	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	297,352	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)	297,352	31.00
31.01	Sequestration adjustment (see instructions)	5,947	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	291,386	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)	19	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0058 Component CCN: 14-5951	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	1,024,567	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,024,567	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	49,613	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	974,954	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	974,954	15.00
15.01	Sequestration adjustment (see instructions)	19,499	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	955,456	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	-1	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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

Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/26/2018 10:27 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	6,179,326	0	0	0	1.00
2.00	Temporary investments	2,429	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	91,234,907	0	0	0	4.00
5.00	Other receivable	4,091,608	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-73,172,800	0	0	0	6.00
7.00	Inventory	1,584,414	0	0	0	7.00
8.00	Prepaid expenses	952,680	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)	30,872,564	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	735,200	0	0	0	12.00
13.00	Land improvements	433,686	0	0	0	13.00
14.00	Accumulated depreciation	-134,883	0	0	0	14.00
15.00	Buildings	11,096,704	0	0	0	15.00
16.00	Accumulated depreciation	-1,267,033	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	14,526,345	0	0	0	19.00
20.00	Accumulated depreciation	-3,287,125	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	17,669,249	0	0	0	23.00
24.00	Accumulated depreciation	-5,911,790	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	702,567	0	0	0	27.00
28.00	Accumulated depreciation	-598,794	0	0	0	28.00
29.00	Minor equipment-nondepreciable	3,232,968	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	37,197,094	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	79,377,234	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	178,000	0	0	0	33.00
34.00	Other assets	24,690,334	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	104,245,568	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	172,315,226	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,279,343	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,044,148	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,443,668	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	5,161,975	0	0	0	43.00
44.00	Other current liabilities	705,666	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,634,800	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	21,424,713	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,540,027	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	30,964,740	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	46,599,540	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	125,715,686				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	125,715,686	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	172,315,226	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/26/2018 10:27 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		113,945,501		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17,887,150				2.00
3.00	Total (sum of line 1 and line 2)		131,832,651		0		3.00
4.00	INTEREST IN TRUST ACCOUNTS	162,000		0		0	4.00
5.00	AFS ROUNDING	41		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		162,041		0		10.00
11.00	Subtotal (line 3 plus line 10)		131,994,692		0		11.00
12.00	ROUNDING	6		0		0	12.00
13.00	TRANSFERS TO/FROM RELATED ORGS	6,261,000		0		0	13.00
14.00	AR STUDENT LOAN CLEAN-UP	18,000		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		6,279,006		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		125,715,686		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	INTEREST IN TRUST ACCOUNTS		0		4.00
5.00	AFS ROUNDING		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		0		12.00
13.00	TRANSFERS TO/FROM RELATED ORGS		0		13.00
14.00	AR STUDENT LOAN CLEAN-UP		0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2018 10:27 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,497,848		17,497,848	1.00
2.00	SUBPROVIDER - IPF	3,662,897		3,662,897	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	6,657,616		6,657,616	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)	27,818,361		27,818,361	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,036,928		6,036,928	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,036,928		6,036,928	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,855,289		33,855,289	17.00
18.00	Ancillary services	84,978,393	225,707,833	310,686,226	18.00
19.00	Outpatient services	4,205,678	26,078,469	30,284,147	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	0	471,991	471,991	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	123,039,360	252,258,293	375,297,653	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		98,435,198		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)		98,435,198		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0058 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/26/2018 10:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	375,297,653	1.00
2.00	Less contractual allowances and discounts on patients' accounts	273,454,701	2.00
3.00	Net patient revenues (line 1 minus line 2)	101,842,952	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	98,435,198	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,407,754	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	31,566	6.00
7.00	Income from investments	2,965,645	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	524,268	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	30,214	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	11,858	21.00
22.00	Rental of hospital space	386,498	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC REVENUE	302,489	24.00
24.01	LIFELINE	648,648	24.01
24.02	EHR	-2,505	24.02
24.03	ASSESSMENT PUBLIC AID	8,872,326	24.03
24.04	UNREALIZED GAINS-LOSSES	3,506,377	24.04
25.00	Total other income (sum of lines 6-24)	17,277,384	25.00
26.00	Total (line 5 plus line 25)	20,685,138	26.00
27.00	NON-OPERATING EXPENSE	3,001,872	27.00
27.01	CHANGE IN INTEREST	-198,317	27.01
27.02	NI OM TEMP RESTRICTED FUNDS	-5,567	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	2,797,988	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	17,887,150	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0058	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/26/2018 10:27 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	925,813	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	47,017	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)	29.02	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)	972,830	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