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: 14-0100	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 10:42 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/28/2017 Time: 10:42 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY 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 MIDWESTERN REGIONAL MEDICAL CENTER (14-0100) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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.

(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	1,408	69,877	67,824	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	1,408	69,877	67,824	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2017 6:28 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2501 EMMAUS AVENUE	PO Box:			1.00
2.00	City: ZION	State: IL	Zip Code: 60099	County: LAKE	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	MIDWESTERN REGIONAL MEDICAL CENTER	140100	29404	1	07/01/1967	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2016	06/30/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2017 6:28 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	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)(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)(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)	Y	Y	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 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		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
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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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 and enter in column 4, 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 and enter in column 4, 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 64-67. (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	
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

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		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.	N			70.00
71.00	If line 70 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)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
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
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109.00

			1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.		N	110.00

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,915,212	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.	N		121.00
122.00	Does the cost report contain state health or similar taxes? 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

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		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H130	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: CTCA	Contractor's Name: FCSO	Contractor's Number: 09001	141.00
142.00	Street: 5900 BROKEN SOUND PARKWAY NW	PO Box:		142.00
143.00	City: BOCA RATON	State: FL	Zip Code: 33487	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.25	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0100	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/18/2017 6:28 am

		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)	07/01/2016	06/30/2017	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 11/18/2017 6:28 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	10/27/2017	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.	Y			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	09/05/2017	Y	09/05/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2017 6:28 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.	N	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?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	Y		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CORY	RUTLEDGE	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-376-4500	CORY.RUTLEDGE@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0100	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/18/2017 6:28 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.	PRINCIPAL		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: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2017 6:28 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	49	17,885	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)		49	17,885	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	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	34.00	0	0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		73	26,645	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		73				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2017 6:28 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)	880	8	5,485			1.00
2.00	HMO and other (see instructions)	95	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	880	8	5,485			7.00
8.00	INTENSIVE CARE UNIT	358	2	5,090			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,238	10	10,575	0.00	1,180.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,180.42	27.00
28.00	Observation Bed Days		1	1,061			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2017 6:28 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	234	3	1,929	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	234	3	1,929	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 11/18/2017 6:28 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 II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	76,281,948	0	76,281,948	2,455,276.67	31.07	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		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,458,618	18,096	7,476,714	291,880.87	25.62	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,382,927	0	2,382,927	19,188.37	124.19	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	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		17,592,674	0	17,592,674	347,567.25	50.62	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)		23,890,221	0	23,890,221			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		3,223,219	0	3,223,219			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		0	0	0			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		13,451,302	0	13,451,302			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	3,259,919	-2,421,754	838,165	20,967.76	39.97	26.00
27.00	Administrative & General	5.00	7,896,292	978,159	8,874,451	268,848.50	33.01	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part II | Date/Time Prepared: 11/18/2017 6:28 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	
28.00	Administrative & General under contract (see inst.)		918,278	0	918,278	2,152.87	426.54	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,900,483	45,771	1,946,254	75,327.09	25.84	30.00
31.00	Laundry & Linen Service	8.00	42,998	0	42,998	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,532,071	36,898	1,568,969	106,622.81	14.72	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,715,416	-1,451,713	263,703	17,272.48	15.27	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	266,429	1,499,444	1,765,873	115,297.92	15.32	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,197,802	66,543	1,264,345	28,158.03	44.90	38.00
39.00	Central Services and Supply	14.00	480,998	11,584	492,582	23,253.78	21.18	39.00
40.00	Pharmacy	15.00	3,323,677	80,046	3,403,723	85,802.14	39.67	40.00
41.00	Medical Records & Medical Records Library	16.00	2,652,757	63,888	2,716,645	94,547.23	28.73	41.00
42.00	Social Service	17.00	711,424	17,134	728,558	31,807.80	22.91	42.00
43.00	Other General Service	18.00	3,096,310	74,571	3,170,881	95,833.74	33.09	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 11/18/2017 6:28 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)		77,200,226	0	77,200,226	2,457,429.54	31.42	1.00
2.00	Excluded area salaries (see instructions)		7,458,618	18,096	7,476,714	291,880.87	25.62	2.00
3.00	Subtotal salaries (line 1 minus line 2)		69,741,608	-18,096	69,723,512	2,165,548.67	32.20	3.00
4.00	Subtotal other wages & related costs (see inst.)		19,975,601	0	19,975,601	366,755.62	54.47	4.00
5.00	Subtotal wage-related costs (see inst.)		37,341,523	0	37,341,523	0.00	53.56	5.00
6.00	Total (sum of lines 3 thru 5)		127,058,732	-18,096	127,040,636	2,532,304.29	50.17	6.00
7.00	Total overhead cost (see instructions)		28,994,854	-999,429	27,995,425	965,892.15	28.98	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 11/18/2017 6:28 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,034,885	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)	12,210,043	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	2,785,531	9.00
10.00	Dental, Hearing and Vision Plan	1,244,011	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	117,408	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	581,254	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1,051,868	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	21,895	14.00
15.00	'Workers' Compensation Insurance	535,989	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	5,355,557	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	638,011	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	536,988	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27,113,440	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: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 11/18/2017 6:28 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	2,382,927	27,113,440	1.00
2.00	Hospital	2,382,927	27,113,440	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet S-10 | Date/Time Prepared: 11/18/2017 6:28 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)	0.230032	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	587,885	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	1,720,627	6.00
7.00	Medicaid cost (line 1 times line 6)	395,799	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)	0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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)	0	23,811,538	23,811,538	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	0	23,811,538	23,811,538	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	23,811,538	23,811,538	23.00

		1.00	
24.00	Does the amount in 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)	8,027,084	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	135,347	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	208,225	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	7,818,859	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,871,466	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	25,683,004	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	25,683,004	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/18/2017 6:28 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		18,452,354	18,452,354	-143,995	18,308,359	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		12,026,567	12,026,567	0	12,026,567	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,259,919	18,681,859	21,941,778	-1,788,171	20,153,607	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,896,292	247,431,557	255,327,849	119,802	255,447,651	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,900,483	5,689,794	7,590,277	45,771	7,636,048	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,998	367,169	410,167	0	410,167	8.00
9.00	00900	HOUSEKEEPING	1,532,071	663,090	2,195,161	36,898	2,232,059	9.00
10.00	01000	DIETARY	1,715,416	2,156,820	3,872,236	-3,284,773	587,463	10.00
11.00	01100	CAFETERIA	266,429	380,213	646,642	3,332,504	3,979,146	11.00
13.00	01300	NURSING ADMINISTRATION	1,197,802	417,865	1,615,667	66,543	1,682,210	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	480,998	576,987	1,057,985	11,584	1,069,569	14.00
15.00	01500	PHARMACY	3,323,677	700,538	4,024,215	80,046	4,104,261	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,652,757	452,522	3,105,279	63,888	3,169,167	16.00
17.00	01700	SOCIAL SERVICE	711,424	237,791	949,215	17,134	966,349	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	3,096,310	725,043	3,821,353	74,571	3,895,924	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,500,574	1,547,674	9,048,248	180,641	9,228,889	30.00
31.00	03100	INTENSIVE CARE UNIT	3,600,224	715,526	4,315,750	86,707	4,402,457	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,077,246	1,927,251	7,004,497	122,279	7,126,776	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,184,268	1,851,461	5,035,729	76,689	5,112,418	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,899,624	3,110,763	5,010,387	45,750	5,056,137	55.00
56.00	05600	RADIOISOTOPE	398,638	76,680	475,318	9,601	484,919	56.00
57.00	05700	CT SCAN	547,446	293,108	840,554	13,185	853,739	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	459,053	385,487	844,540	11,056	855,596	58.00
60.00	06000	LABORATORY	2,830,203	4,170,353	7,000,556	68,162	7,068,718	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,183,434	1,183,434	0	1,183,434	63.00
64.00	06400	INTRAVENOUS THERAPY	1,883,135	273,808	2,156,943	45,353	2,202,296	64.00
65.00	06500	RESPIRATORY THERAPY	959,010	468,217	1,427,227	23,096	1,450,323	65.00
66.00	06600	PHYSICAL THERAPY	1,261,184	292,026	1,553,210	30,374	1,583,584	66.00
69.00	06900	ELECTROCARDIOLOGY	443,762	119,149	562,911	10,687	573,598	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,809,109	15,809,109	0	15,809,109	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	95,472,021	95,472,021	0	95,472,021	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	710,494	110,537	821,031	17,111	838,142	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	9,205,099	1,312,237	10,517,336	221,693	10,739,029	90.00
91.00	09100	EMERGENCY	786,794	198,666	985,460	18,949	1,004,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		665,091	665,091	-338,712	326,379	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	68,823,330	438,942,767	507,766,097	-725,577	507,040,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,961	24,961	0	24,961	190.00
191.00	19100	RESEARCH	342,554	92,651	435,205	8,250	443,455	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	7,116,064	26,218,802	33,334,866	717,327	34,052,193	194.00
200.00		TOTAL (SUM OF LINES 118-199)	76,281,948	465,279,181	541,561,129	0	541,561,129	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A | Date/Time Prepared: 11/18/2017 6:28 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	-6,786,022	11,522,337		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,602,626	14,629,193		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-97,617	20,055,990		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-189,720,776	65,726,875		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-9	7,636,039		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	410,167		8.00
9.00	00900	HOUSEKEEPING	837	2,232,896		9.00
10.00	01000	DIETARY	-39	587,424		10.00
11.00	01100	CAFETERIA	-2,864,188	1,114,958		11.00
13.00	01300	NURSING ADMINISTRATION	-669	1,681,541		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-13	1,069,556		14.00
15.00	01500	PHARMACY	150	4,104,411		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,607	3,162,560		16.00
17.00	01700	SOCIAL SERVICE	-61,357	904,992		17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	-24,358	3,871,566		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-68	9,228,821		30.00
31.00	03100	INTENSIVE CARE UNIT	-450	4,402,007		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-29	7,126,747		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-61	5,112,357		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-473	5,055,664		55.00
56.00	05600	RADIOISOTOPE	0	484,919		56.00
57.00	05700	CT SCAN	0	853,739		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	855,596		58.00
60.00	06000	LABORATORY	0	7,068,718		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	-37,394	1,146,040		63.00
64.00	06400	INTRAVENOUS THERAPY	-34,986	2,167,310		64.00
65.00	06500	RESPIRATORY THERAPY	125	1,450,448		65.00
66.00	06600	PHYSICAL THERAPY	-370	1,583,214		66.00
69.00	06900	ELECTROCARDIOLOGY	0	573,598		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,809,109		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	95,472,021		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	838,142		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-20	10,739,009		90.00
91.00	09100	EMERGENCY	0	1,004,409		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-326,379	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-197,358,147	309,682,373		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,961		190.00
191.00	19100	RESEARCH	0	443,455		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	34,052,193		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-197,358,147	344,202,982		200.00

RECLASSIFICATIONS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/18/2017 6:28 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RECLASS CAFETERIA				
1.00	CAFETERIA	11.00	1,493,027	1,833,060	1.00
	0		1,493,027	1,833,060	
	B - EMPLOYEE BONUS				
1.00	ADMINISTRATIVE & GENERAL	5.00	816,624	0	1.00
2.00	OPERATION OF PLANT	7.00	45,771	0	2.00
3.00	HOUSEKEEPING	9.00	36,898	0	3.00
4.00	DIETARY	10.00	41,314	0	4.00
5.00	CAFETERIA	11.00	6,417	0	5.00
6.00	NURSING ADMINISTRATION	13.00	66,543	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	11,584	0	7.00
8.00	PHARMACY	15.00	80,046	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	63,888	0	9.00
10.00	SOCIAL SERVICE	17.00	17,134	0	10.00
11.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	74,571	0	11.00
12.00	ADULTS & PEDIATRICS	30.00	180,641	0	12.00
13.00	INTENSIVE CARE UNIT	31.00	86,707	0	13.00
14.00	OPERATING ROOM	50.00	122,279	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	76,689	0	15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	45,750	0	16.00
17.00	RADIOISOTOPE	56.00	9,601	0	17.00
18.00	CT SCAN	57.00	13,185	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	11,056	0	19.00
20.00	LABORATORY	60.00	68,162	0	20.00
21.00	INTRAVENOUS THERAPY	64.00	45,353	0	21.00
22.00	RESPIRATORY THERAPY	65.00	23,096	0	22.00
23.00	PHYSICAL THERAPY	66.00	30,374	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	10,687	0	24.00
25.00	HOSPITAL NUTRITION	76.01	17,111	0	25.00
27.00	CLINIC	90.00	221,693	0	27.00
28.00	EMERGENCY	91.00	18,949	0	28.00
30.00	RESEARCH	191.00	8,250	0	30.00
31.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	171,381	0	31.00
	0		2,421,754	0	
	C - PROPERTY TAX				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	900,202	1.00
	0		0	900,202	
	D - TRAVEL/SCHEDULING				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	51,431	6,952	1.00
	0		51,431	6,952	
	E - GUEST SERVICES				
1.00		0.00	0	0	1.00
	0		0	0	
	F - INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	338,712	1.00
	0		0	338,712	
	G - INSURANCE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	425,498	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	633,583	2.00
	0		0	1,059,081	
	H - TRANSPORTATION				
1.00	ADMINISTRATIVE & GENERAL	5.00	212,966	207,676	1.00
	0		212,966	207,676	
	I - GUEST ACCOMODATIONS DEPRECIATION				
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	0	8,003	1.00
	TOTALS		0	8,003	
500.00	Grand Total: Increases		4,179,178	4,353,686	500.00

RECLASSIFICATIONS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-6 | Date/Time Prepared: 11/18/2017 6:28 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA						
1.00	DIETARY	10.00	1,493,027	1,833,060	0		1.00
	0		1,493,027	1,833,060			
	B - EMPLOYEE BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	2,421,754	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
	0		2,421,754	0			
	C - PROPERTY TAX						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	900,202	13		1.00
	0		0	900,202			
	D - TRAVEL/SCHEDULING						
1.00	ADMINISTRATIVE & GENERAL	5.00	51,431	6,952	0		1.00
	0		51,431	6,952			
	E - GUEST SERVICES						
1.00		0.00	0	0	0		1.00
	0		0	0			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	338,712	11		1.00
	0		0	338,712			
	G - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,059,081	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	1,059,081			
	H - TRANSPORTATION						
1.00	OTHER NONREIMBURSABLE COST CENTERS	194.00	212,966	207,676	0		1.00
	0		212,966	207,676			
	I - GUEST ACCOMODATIONS DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,003	9		1.00
	TOTALS		0	8,003			
500.00	Grand Total: Decreases		4,179,178	4,353,686			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 11/18/2017 6:28 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	1,126,605	0	0	0	0	2.00
3.00	Buildings and Fixtures	112,867,007	12,223,653	0	12,223,653	89,229,006	3.00
4.00	Building Improvements	73,843,535	91,488,987	0	91,488,987	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	85,072,105	11,508,014	0	11,508,014	3,840,552	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	272,909,252	115,220,654	0	115,220,654	93,069,558	8.00
9.00	Reconciling Items	77,247,042	24,320,247	0	24,320,247	9,876,164	9.00
10.00	Total (line 8 minus line 9)	195,662,210	90,900,407	0	90,900,407	83,193,394	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	0	0	1.00
2.00	Land Improvements	1,126,605	0	2.00
3.00	Buildings and Fixtures	35,861,654	0	3.00
4.00	Building Improvements	165,332,522	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	92,739,567	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	295,060,348	0	8.00
9.00	Reconciling Items	91,691,125	0	9.00
10.00	Total (line 8 minus line 9)	203,369,223	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 11/18/2017 6:28 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	8,044,562	0	0	45,596	4,852,385	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,131,996	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	17,176,558	0	0	45,596	4,852,385	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	5,509,811	18,452,354	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,894,571	12,026,567	2.00
3.00	Total (sum of lines 1-2)	8,404,382	30,478,921	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2017 6:28 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	202,320,781	30,678,145	171,642,636	0.793188	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	92,739,566	47,986,314	44,753,252	0.206812	0	2.00
3.00	Total (sum of lines 1-2)	295,060,347	78,664,459	216,395,888	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	7,235,384	-5,211,444	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,852,626	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,088,010	-5,211,444	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	-394,902	431,305	3,952,183	5,509,811	11,522,337	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,776,567	14,629,193	2.00
3.00	Total (sum of lines 1-2)	-394,902	431,305	3,952,183	7,286,378	26,151,530	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/18/2017 6:28 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	-733,614	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			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	-179,854,261			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,842,145	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	50	ADMINISTRATIVE & GENERAL	5.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-2,694,145	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-747,828	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER REVENUE	B	-34,986	INTRAVENOUS THERAPY	64.00	0	33.00
33.01	OTHER REVENUE	B	-3,554,923	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8 | Date/Time Prepared: 11/18/2017 6:28 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	OTHER REVENUE	B	-37,394	BLOOD STORING, PROCESSING & TRANS.	63.00	0	33.02
33.03	OTHER REVENUE	B	50	SOCIAL SERVICE	17.00	0	33.03
33.04	OTHER REVENUE	B	-6,607	MEDICAL RECORDS & LIBRARY	16.00	0	33.04
33.05	OTHER REVENUE	B	664	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	33.05
34.00	OTHER REVENUE	B	-600	NURSING ADMINISTRATION	13.00	0	34.00
34.01	OTHER REVENUE	B	-450	INTENSIVE CARE UNIT	31.00	0	34.01
34.02	OTHER REVENUE	B	-370	PHYSICAL THERAPY	66.00	0	34.02
34.03	OTHER REVENUE	B	150	PHARMACY	15.00	0	34.03
34.04	NON-ALLOWABLE EXPENSE	A	-61,407	SOCIAL SERVICE	17.00	0	34.04
34.05	NON-ALLOWABLE EXPENSE	A	-68	ADULTS & PEDIATRICS	30.00	0	34.05
34.06	NON-ALLOWABLE EXPENSE	A	-29	OPERATING ROOM	50.00	0	34.06
34.07	NON-ALLOWABLE EXPENSE	A	-61	RADIOLOGY-DIAGNOSTIC	54.00	0	34.07
34.08	NON-ALLOWABLE EXPENSE	A	-25,022	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	34.08
34.09	NON-ALLOWABLE EXPENSE	A	-39	DIETARY	10.00	0	34.09
34.10	NON-ALLOWABLE EXPENSE	A	-6,702,789	ADMINISTRATIVE & GENERAL	5.00	0	34.10
34.11	NON-ALLOWABLE EXPENSE	A	-23	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.11
34.12	NON-ALLOWABLE EXPENSE	A	-9	OPERATION OF PLANT	7.00	0	34.12
34.13	NON-ALLOWABLE EXPENSE	A	837	HOUSEKEEPING	9.00	0	34.13
34.14	NON-ALLOWABLE EXPENSE	A	-473	RADIOLOGY-THERAPEUTIC	55.00	0	34.14
34.15	NON-ALLOWABLE EXPENSE	A	125	RESPIRATORY THERAPY	65.00	0	34.15
34.16	NON-ALLOWABLE EXPENSE	A	-14	CAFETERIA	11.00	0	34.16
34.17	CAFETERIA	A	-1,022,029	CAFETERIA	11.00	0	34.17
34.18	NON-ALLOWABLE EXPENSE	A	-20	CLINIC	90.00	0	34.18
34.19	NON-ALLOWABLE EXPENSE	A	-69	NURSING ADMINISTRATION	13.00	0	34.19
34.20	NON-ALLOWABLE EXPENSE	A	-13	CENTRAL SERVICES & SUPPLY	14.00	0	34.20
34.21	EMR AMORTIZATION	A	-40,635	ADMINISTRATIVE & GENERAL	5.00	0	34.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-197,358,147				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2017 6:28 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	0.00		MANAGEMENT FEES	0	0	1.00
2.00	0.00		RISING TIDE IP REIMBURSEMENT	0	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	TRAVEL - AIR CHARTER	88,278	3,174,000	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	GUARANTEE FEES	0	121,015	4.00
4.01	113.00	INTEREST EXPENSE	INTEREST EXPENSE - OTHER	0	95,625	4.01
4.02	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES	6,712,231	6,712,231	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	AMORT EXP - GCF CAP LEASES -	0	1,118,004	4.03
4.04	113.00	INTEREST EXPENSE	INTEREST EXPENSE - GCF	0	569,466	4.04
4.05	113.00	INTEREST EXPENSE	INTEREST EXPENSE - CAPITAL L	338,712	0	4.05
4.06	1.00	CAP REL COSTS-BLDG & FIXT	RENTAL - BLDG	261,356	5,472,800	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	SHARED SERVICES - NEW	0	39,751,143	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE	0	185,505,856	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	INSURANCE	385,709	425,498	4.09
4.10	4.00	EMPLOYEE BENEFITS DEPARTMENT	INSURANCE	535,989	633,583	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	INSURANCE	1,947,115	4,542,914	4.11
4.12	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1,892,970	0	4.12
4.13	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	4,468,458	0	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	52,033,083	0	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	BROKERAGE FEES	0	396,027	4.15
5.00	0		0	68,663,901	248,518,162	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	A	MIDWESTERN REG	100.00	NIMP	100.00	6.00
7.00	A	MIDWESTERN REG	100.00	CTCA	100.00	7.00
8.00	A	MIDWESTERN REG	100.00	ICIC	100.00	8.00
9.00	A	MIDWESTERN REG	100.00	INTERNATIONAL A	100.00	9.00
10.00	A	MIDWESTERN REG	100.00	SCL	100.00	10.00
10.01	A	MIDWESTERN REG	100.00	EXPEDITION PROP	100.00	10.01
10.02	A	MIDWESTERN REG	100.00	BUCKLEY RD PR	100.00	10.02
10.03	A	MIDWESTERN REG	100.00	LAND TRUST	100.00	10.03
10.04	A	MIDWESTERN REG	100.00	GCF	100.00	10.04
10.05	A	MIDWESTERN REG	100.00	STELLAR INS	100.00	10.05
10.06	A	MIDWESTERN REG	100.00	ICMC	100.00	10.06
10.07			0.00		0.00	10.07
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: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2017 6:28 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	0	0		1.00
2.00	0	0		2.00
3.00	-3,085,722	0		3.00
4.00	-121,015	0		4.00
4.01	-95,625	0		4.01
4.02	0	14		4.02
4.03	-1,118,004	14		4.03
4.04	-569,466	0		4.04
4.05	338,712	0		4.05
4.06	-5,211,444	10		4.06
4.07	-39,751,143	0		4.07
4.08	-185,505,856	0		4.08
4.09	-39,789	12		4.09
4.10	-97,594	0		4.10
4.11	-2,595,799	0		4.11
4.12	1,892,970	9		4.12
4.13	4,468,458	9		4.13
4.14	52,033,083	0		4.14
4.15	-396,027	0		4.15
5.00	-179,854,261			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	PROPERTY		6.00
7.00	MANAGEMENT		7.00
8.00	CONSULTING		8.00
9.00	CORPORATE JET		9.00
10.00	SECURITIES FINA		10.00
10.01	RENTS BLDG SHAR		10.01
10.02	PROPERTY COMP		10.02
10.03	PROPERTY COMP		10.03
10.04	FINANCIAL		10.04
10.05	INSURANCE		10.05
10.06	CAPITAL MANAGEM		10.06
10.07			10.07
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: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 11/18/2017 6:28 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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0		0	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	0.00		0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	0.00		0	0	0	0		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/18/2017 6:28 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	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,522,337	11,522,337				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	14,629,193		14,629,193			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	20,055,990	261,875	5,737	20,323,602		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	65,726,875	430,258	4,238,614	2,390,662	72,786,409	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,636,039	2,054,837	485,930	524,296	10,701,102	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	410,167	0	0	11,583	421,750	8.00
9.00	00900	HOUSEKEEPING	2,232,896	192,373	31,660	422,660	2,879,589	9.00
10.00	01000	DIETARY	587,424	19,473	175,411	71,038	853,346	10.00
11.00	01100	CAFETERIA	1,114,958	743,870	18,349	475,703	2,352,880	11.00
13.00	01300	NURSING ADMINISTRATION	1,681,541	31,050	325	340,598	2,053,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,069,556	141,585	831,729	132,695	2,175,565	14.00
15.00	01500	PHARMACY	4,104,411	133,462	345,617	916,919	5,500,409	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,162,560	148,835	0	731,829	4,043,224	16.00
17.00	01700	SOCIAL SERVICE	904,992	83,395	409	196,264	1,185,060	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	3,871,566	266,164	705	854,194	4,992,629	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,228,821	1,902,853	123,221	2,069,219	13,324,114	30.00
31.00	03100	INTENSIVE CARE UNIT	4,402,007	688,641	271,550	993,211	6,355,409	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,126,747	753,663	2,032,134	1,400,684	11,313,228	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,112,357	415,910	1,630,999	878,459	8,037,725	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,055,664	490,840	1,935,097	524,058	8,005,659	55.00
56.00	05600	RADIOISOTOPE	484,919	15,183	165,489	109,974	775,565	56.00
57.00	05700	CT SCAN	853,739	25,128	207,344	151,027	1,237,238	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	855,596	56,406	881,739	126,641	1,920,382	58.00
60.00	06000	LABORATORY	7,068,718	316,231	313,470	780,782	8,479,201	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,146,040	11,084	164,022	0	1,321,146	63.00
64.00	06400	INTRAVENOUS THERAPY	2,167,310	333,578	94,220	519,510	3,114,618	64.00
65.00	06500	RESPIRATORY THERAPY	1,450,448	78,232	46,547	264,567	1,839,794	65.00
66.00	06600	PHYSICAL THERAPY	1,583,214	95,617	11,325	347,929	2,038,085	66.00
69.00	06900	ELECTROCARDIOLOGY	573,598	9,717	113,950	122,423	819,688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,809,109	0	0	0	15,809,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	95,472,021	0	0	0	95,472,021	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	838,142	27,975	1,392	196,007	1,063,516	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,739,009	1,574,323	104,908	2,539,483	14,957,723	90.00
91.00	09100	EMERGENCY	1,004,409	87,304	42,418	217,057	1,351,188	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 1-117)	309,682,373	11,389,862	14,274,311	18,309,472	307,180,886	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24,961	40,008	0	0	64,969	190.00
191.00	19100	RESEARCH	443,455	0	953	94,502	538,910	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	34,052,193	92,467	353,929	1,919,628	36,418,217	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 118-201)	344,202,982	11,522,337	14,629,193	20,323,602	344,202,982	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	72,786,409					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,869,736	0	13,570,838			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	113,102	0	0	534,852		8.00
9.00	00900	HOUSEKEEPING	772,225	0	257,675	0	3,909,489	9.00
10.00	01000	DIETARY	228,844	0	26,083	0	8,870	10.00
11.00	01100	CAFETERIA	630,977	0	996,380	0	338,827	11.00
13.00	01300	NURSING ADMINISTRATION	550,695	0	41,590	0	14,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	583,426	0	189,646	0	64,491	14.00
15.00	01500	PHARMACY	1,475,056	0	178,766	0	60,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,084,279	0	199,357	0	67,793	16.00
17.00	01700	SOCIAL SERVICE	317,800	0	111,703	0	37,986	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	1,338,883	0	356,515	3,842	121,236	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,573,154	0	2,548,784	110,183	866,733	30.00
31.00	03100	INTENSIVE CARE UNIT	1,704,343	0	922,403	74,814	313,671	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,033,891	0	1,009,497	84,239	343,288	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,155,493	0	557,092	103,913	189,444	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,146,894	0	657,457	55,125	223,574	55.00
56.00	05600	RADIOISOTOPE	207,985	0	20,337	0	6,916	56.00
57.00	05700	CT SCAN	331,793	0	33,658	0	11,446	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	514,993	0	75,553	0	25,693	58.00
60.00	06000	LABORATORY	2,273,884	0	423,577	0	144,041	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	354,294	0	14,846	0	5,049	63.00
64.00	06400	INTRAVENOUS THERAPY	835,253	0	446,813	50,324	151,942	64.00
65.00	06500	RESPIRATORY THERAPY	493,381	0	104,788	1,148	35,634	65.00
66.00	06600	PHYSICAL THERAPY	546,557	0	128,075	12,384	43,553	66.00
69.00	06900	ELECTROCARDIOLOGY	219,817	0	13,016	4,528	4,426	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,239,560	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	25,603,006	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	285,205	0	37,472	0	12,743	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,011,242	0	2,108,734	25,793	717,092	90.00
91.00	09100	EMERGENCY	362,351	0	116,940	4,407	39,766	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 1-117)	62,858,119	0	11,576,757	530,700	3,849,148	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	17,423	0	53,589	0	18,223	190.00
191.00	19100	RESEARCH	144,521	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	9,766,346	0	1,940,492	4,152	42,118	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 118-201)	72,786,409	0	13,570,838	534,852	3,909,489	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,117,143					10.00
11.00	01100	CAFETERIA	0	4,319,064				11.00
13.00	01300	NURSING ADMINISTRATION	0	65,786	2,725,728			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	54,329	0	3,067,457		14.00
15.00	01500	PHARMACY	0	200,460	0	0	7,415,482	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	220,891	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	74,313	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	223,898	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	812,876	512,343	1,080,617	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	246,523	519,957	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	345,720	729,181	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	224,550	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	120,269	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	19,688	0	0	0	56.00
57.00	05700	CT SCAN	0	33,655	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	25,718	0	0	0	58.00
60.00	06000	LABORATORY	0	235,222	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	297,087	118,206	249,315	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	64,499	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	90,710	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	25,690	54,185	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3,067,457	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	7,415,482	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	58,277	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	632,551	0	0	0	90.00
91.00	09100	EMERGENCY	7,180	43,843	92,473	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 1-117)	1,117,143	3,637,141	2,725,728	3,067,457	7,415,482	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	19,447	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	662,476	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 118-201)	1,117,143	4,319,064	2,725,728	3,067,457	7,415,482	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,615,544					16.00
17.00	01700	SOCIAL SERVICE	0	1,726,862				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	7,037,003			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,991	31,985	130,309	23,095,089	0	30.00
31.00	03100	INTENSIVE CARE UNIT	63,353	19,486	79,387	10,299,346	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	429,484	132,096	538,177	17,958,801	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231,137	71,091	289,632	11,860,077	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	364,961	112,251	457,324	12,143,514	0	55.00
56.00	05600	RADIOISOTOPE	26,121	8,034	32,732	1,097,378	0	56.00
57.00	05700	CT SCAN	392,414	120,695	491,725	2,652,624	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	99,980	30,751	125,283	2,818,353	0	58.00
60.00	06000	LABORATORY	356,376	109,610	446,566	12,468,477	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	33,186	10,207	41,585	1,780,313	0	63.00
64.00	06400	INTRAVENOUS THERAPY	153,758	47,291	192,670	5,657,277	0	64.00
65.00	06500	RESPIRATORY THERAPY	20,725	6,374	25,970	2,592,313	0	65.00
66.00	06600	PHYSICAL THERAPY	17,793	5,473	22,296	2,904,926	0	66.00
69.00	06900	ELECTROCARDIOLOGY	36,140	11,116	45,287	1,233,893	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	168,945	51,962	211,702	23,548,735	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	3,057,985	940,233	3,832,183	136,320,910	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	6,309	1,941	7,906	1,473,369	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,424	11,511	46,895	22,548,965	0	90.00
91.00	09100	EMERGENCY	15,462	4,755	19,374	2,057,739	0	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 1-117)	5,615,544	1,726,862	7,037,003	294,512,099	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	154,204	0	190.00
191.00	19100	RESEARCH	0	0	0	702,878	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	48,833,801	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,615,544	1,726,862	7,037,003	344,202,982	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part I | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	23,095,089		30.00
31.00	03100	INTENSIVE CARE UNIT	10,299,346		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	17,958,801		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,860,077		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,143,514		55.00
56.00	05600	RADIOISOTOPE	1,097,378		56.00
57.00	05700	CT SCAN	2,652,624		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,818,353		58.00
60.00	06000	LABORATORY	12,468,477		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,780,313		63.00
64.00	06400	INTRAVENOUS THERAPY	5,657,277		64.00
65.00	06500	RESPIRATORY THERAPY	2,592,313		65.00
66.00	06600	PHYSICAL THERAPY	2,904,926		66.00
69.00	06900	ELECTROCARDIOLOGY	1,233,893		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,548,735		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,320,910		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	1,473,369		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	22,548,965		90.00
91.00	09100	EMERGENCY	2,057,739		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 1-117)	294,512,099		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	154,204		190.00
191.00	19100	RESEARCH	702,878		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	48,833,801		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	344,202,982		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II Date/Time Prepared: 11/18/2017 6:28 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	261,875	5,737	267,612	267,612	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	430,258	4,238,614	4,668,872	31,478	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,054,837	485,930	2,540,767	6,903	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	153	8.00
9.00	00900	HOUSEKEEPING	0	192,373	31,660	224,033	5,565	9.00
10.00	01000	DIETARY	0	19,473	175,411	194,884	935	10.00
11.00	01100	CAFETERIA	0	743,870	18,349	762,219	6,264	11.00
13.00	01300	NURSING ADMINISTRATION	0	31,050	325	31,375	4,485	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	141,585	831,729	973,314	1,747	14.00
15.00	01500	PHARMACY	0	133,462	345,617	479,079	12,073	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	148,835	0	148,835	9,636	16.00
17.00	01700	SOCIAL SERVICE	0	83,395	409	83,804	2,584	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	266,164	705	266,869	11,247	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,902,853	123,221	2,026,074	27,245	30.00
31.00	03100	INTENSIVE CARE UNIT	0	688,641	271,550	960,191	13,078	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	753,663	2,032,134	2,785,797	18,443	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	415,910	1,630,999	2,046,909	11,567	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	490,840	1,935,097	2,425,937	6,900	55.00
56.00	05600	RADIOISOTOPE	0	15,183	165,489	180,672	1,448	56.00
57.00	05700	CT SCAN	0	25,128	207,344	232,472	1,989	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	56,406	881,739	938,145	1,667	58.00
60.00	06000	LABORATORY	0	316,231	313,470	629,701	10,281	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	11,084	164,022	175,106	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	333,578	94,220	427,798	6,840	64.00
65.00	06500	RESPIRATORY THERAPY	0	78,232	46,547	124,779	3,484	65.00
66.00	06600	PHYSICAL THERAPY	0	95,617	11,325	106,942	4,581	66.00
69.00	06900	ELECTROCARDIOLOGY	0	9,717	113,950	123,667	1,612	69.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	27,975	1,392	29,367	2,581	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,574,323	104,908	1,679,231	33,448	90.00
91.00	09100	EMERGENCY	0	87,304	42,418	129,722	2,858	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 1-117)	0	11,389,862	14,274,311	25,664,173	241,092	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,008	0	40,008	0	190.00
191.00	19100	RESEARCH	0	0	953	953	1,244	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	92,467	353,929	446,396	25,276	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 118-201)	0	11,522,337	14,629,193	26,151,530	267,612	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,700,350					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	185,322	0	2,732,992			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,304	0	0	7,457		8.00
9.00	00900	HOUSEKEEPING	49,869	0	51,892	0	331,359	9.00
10.00	01000	DIETARY	14,778	0	5,253	0	752	10.00
11.00	01100	CAFETERIA	40,747	0	200,658	0	28,718	11.00
13.00	01300	NURSING ADMINISTRATION	35,563	0	8,376	0	1,199	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,676	0	38,192	0	5,466	14.00
15.00	01500	PHARMACY	95,256	0	36,001	0	5,152	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	70,021	0	40,148	0	5,746	16.00
17.00	01700	SOCIAL SERVICE	20,523	0	22,496	0	3,220	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	86,462	0	71,797	54	10,276	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	230,747	0	513,294	1,535	73,461	30.00
31.00	03100	INTENSIVE CARE UNIT	110,063	0	185,760	1,043	26,586	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	195,922	0	203,300	1,174	29,096	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	139,197	0	112,191	1,449	16,057	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	138,642	0	132,403	769	18,950	55.00
56.00	05600	RADIOISOTOPE	13,431	0	4,096	0	586	56.00
57.00	05700	CT SCAN	21,426	0	6,778	0	970	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33,257	0	15,215	0	2,178	58.00
60.00	06000	LABORATORY	146,843	0	85,303	0	12,209	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	22,880	0	2,990	0	428	63.00
64.00	06400	INTRAVENOUS THERAPY	53,939	0	89,982	702	12,878	64.00
65.00	06500	RESPIRATORY THERAPY	31,862	0	21,103	16	3,020	65.00
66.00	06600	PHYSICAL THERAPY	35,296	0	25,793	173	3,691	66.00
69.00	06900	ELECTROCARDIOLOGY	14,195	0	2,621	63	375	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	273,782	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	1,653,342	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	18,418	0	7,546	0	1,080	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	259,038	0	424,672	360	60,779	90.00
91.00	09100	EMERGENCY	23,400	0	23,550	61	3,371	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 1-117)	4,059,201	0	2,331,410	7,399	326,244	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,125	0	10,792	0	1,545	190.00
191.00	19100	RESEARCH	9,333	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	630,691	0	390,790	58	3,570	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 118-201)	4,700,350	0	2,732,992	7,457	331,359	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B Part II | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	216,602					10.00
11.00	01100	CAFETERIA	0	1,038,606				11.00
13.00	01300	NURSING ADMINISTRATION	0	15,820	96,818			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,064	0	1,069,459		14.00
15.00	01500	PHARMACY	0	48,205	0	0	675,766	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	53,118	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	17,870	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	53,841	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	157,608	123,203	38,382	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	59,281	18,469	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	83,135	25,901	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	53,998	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	28,921	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	4,734	0	0	0	56.00
57.00	05700	CT SCAN	0	8,093	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	6,184	0	0	0	58.00
60.00	06000	LABORATORY	0	56,564	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	57,602	28,425	8,856	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,510	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,813	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,178	1,925	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,069,459	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	675,766	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	14,014	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	152,110	0	0	0	90.00
91.00	09100	EMERGENCY	1,392	10,543	3,285	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 1-117)	216,602	874,624	96,818	1,069,459	675,766	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	4,677	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	159,305	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 118-201)	216,602	1,038,606	96,818	1,069,459	675,766	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY)	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	18.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	327,504					16.00
17.00	01700	SOCIAL SERVICE	0	150,497				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	500,546			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,070	2,798	9,271	3,209,688	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,698	1,704	5,648	1,385,521	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	25,068	11,555	38,287	3,417,678	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,491	6,218	20,605	2,421,682	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	21,302	9,819	32,535	2,816,178	0	55.00
56.00	05600	RADIOISOTOPE	1,525	703	2,329	209,524	0	56.00
57.00	05700	CT SCAN	22,904	10,557	34,983	340,172	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,836	2,690	8,913	1,014,085	0	58.00
60.00	06000	LABORATORY	20,801	9,588	31,770	1,003,060	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,937	893	2,958	207,192	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,974	4,137	13,707	713,840	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,210	558	1,848	203,390	0	65.00
66.00	06600	PHYSICAL THERAPY	1,039	479	1,586	201,393	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,109	972	3,222	156,939	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,861	4,545	15,061	1,372,708	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	178,225	81,688	272,547	2,861,568	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	368	170	562	74,106	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,184	1,007	3,336	2,616,165	0	90.00
91.00	09100	EMERGENCY	902	416	1,378	200,878	0	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 1-117)	327,504	150,497	500,546	24,425,767	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	53,470	0	190.00
191.00	19100	RESEARCH	0	0	0	16,207	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,656,086	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	327,504	150,497	500,546	26,151,530	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)			18.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,209,688		30.00
31.00	03100	INTENSIVE CARE UNIT	1,385,521		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,417,678		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,421,682		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,816,178		55.00
56.00	05600	RADIOISOTOPE	209,524		56.00
57.00	05700	CT SCAN	340,172		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,014,085		58.00
60.00	06000	LABORATORY	1,003,060		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	207,192		63.00
64.00	06400	INTRAVENOUS THERAPY	713,840		64.00
65.00	06500	RESPIRATORY THERAPY	203,390		65.00
66.00	06600	PHYSICAL THERAPY	201,393		66.00
69.00	06900	ELECTROCARDIOLOGY	156,939		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,372,708		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,861,568		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		76.00
76.01	03951	HOSPITAL NUTRITION	74,106		76.01
76.02	03952	PAIN MANAGEMENT	0		76.02
76.03	03954	INFUSION CENTER	0		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2,616,165		90.00
91.00	09100	EMERGENCY	200,878		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 1-117)	24,425,767		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	53,470		190.00
191.00	19100	RESEARCH	16,207		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	1,656,086		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	26,151,530		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	303,552					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		14,634,122				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,899	5,739	75,443,782			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,335	4,240,041	8,874,451	-72,786,409	271,416,573	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	54,134	486,094	1,946,254	0	10,701,102	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	42,998	0	421,750	8.00
9.00	00900	HOUSEKEEPING	5,068	31,671	1,568,969	0	2,879,589	9.00
10.00	01000	DIETARY	513	175,470	263,702	0	853,346	10.00
11.00	01100	CAFETERIA	19,597	18,355	1,765,873	0	2,352,880	11.00
13.00	01300	NURSING ADMINISTRATION	818	325	1,264,345	0	2,053,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	832,009	492,582	0	2,175,565	14.00
15.00	01500	PHARMACY	3,516	345,734	3,403,723	0	5,500,409	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	0	2,716,645	0	4,043,224	16.00
17.00	01700	SOCIAL SERVICE	2,197	409	728,558	0	1,185,060	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	7,012	705	3,170,881	0	4,992,629	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,130	123,263	7,681,215	0	13,324,114	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	271,642	3,686,931	0	6,355,409	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,855	2,032,819	5,199,525	0	11,313,228	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,957	1,631,549	3,260,957	0	8,037,725	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	1,935,749	1,945,374	0	8,005,659	55.00
56.00	05600	RADIOISOTOPE	400	165,545	408,239	0	775,565	56.00
57.00	05700	CT SCAN	662	207,414	560,631	0	1,237,238	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	882,036	470,109	0	1,920,382	58.00
60.00	06000	LABORATORY	8,331	313,576	2,898,365	0	8,479,201	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	164,077	0	0	1,321,146	63.00
64.00	06400	INTRAVENOUS THERAPY	8,788	94,252	1,928,488	0	3,114,618	64.00
65.00	06500	RESPIRATORY THERAPY	2,061	46,563	982,106	0	1,839,794	65.00
66.00	06600	PHYSICAL THERAPY	2,519	11,329	1,291,558	0	2,038,085	66.00
69.00	06900	ELECTROCARDIOLOGY	256	113,988	454,449	0	819,688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	15,809,109	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	95,472,021	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	1,392	727,605	0	1,063,516	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	41,475	104,943	9,426,792	0	14,957,723	90.00
91.00	09100	EMERGENCY	2,300	42,432	805,743	0	1,351,188	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 1-117)	300,062	14,279,121	67,967,068	-72,786,409	234,394,477	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	0	0	0	64,969	190.00
191.00	19100	RESEARCH	0	953	350,804	0	538,910	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,436	354,048	7,125,910	0	36,418,217	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)	11,522,337	14,629,193	20,323,602		72,786,409	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	37.958363	0.999663	0.269387		0.268172	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			267,612		4,700,350	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003547		0.017318	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	285,318					6.00
7.00	00700	OPERATION OF PLANT	54,134	266,914				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	574,091			8.00
9.00	00900	HOUSEKEEPING	5,068	5,068	0	226,116		9.00
10.00	01000	DIETARY	513	513	0	513	44,966	10.00
11.00	01100	CAFETERIA	19,597	19,597	0	19,597	0	11.00
13.00	01300	NURSING ADMINISTRATION	818	818	0	818	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,730	3,730	0	3,730	0	14.00
15.00	01500	PHARMACY	3,516	3,516	0	3,516	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,921	3,921	0	3,921	0	16.00
17.00	01700	SOCIAL SERVICE	2,197	2,197	0	2,197	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	7,012	7,012	4,124	7,012	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,130	50,130	118,266	50,130	32,719	30.00
31.00	03100	INTENSIVE CARE UNIT	18,142	18,142	80,303	18,142	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,855	19,855	90,419	19,855	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,957	10,957	111,537	10,957	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,931	12,931	59,169	12,931	0	55.00
56.00	05600	RADIOISOTOPE	400	400	0	400	0	56.00
57.00	05700	CT SCAN	662	662	0	662	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,486	1,486	0	1,486	0	58.00
60.00	06000	LABORATORY	8,331	8,331	0	8,331	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	292	292	0	292	0	63.00
64.00	06400	INTRAVENOUS THERAPY	8,788	8,788	54,016	8,788	11,958	64.00
65.00	06500	RESPIRATORY THERAPY	2,061	2,061	1,232	2,061	0	65.00
66.00	06600	PHYSICAL THERAPY	2,519	2,519	13,293	2,519	0	66.00
69.00	06900	ELECTROCARDIOLOGY	256	256	4,860	256	0	69.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	737	737	0	737	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	41,475	41,475	27,685	41,475	0	90.00
91.00	09100	EMERGENCY	2,300	2,300	4,730	2,300	289	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 1-117)	281,828	227,694	569,634	222,626	44,966	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,054	1,054	0	1,054	0	190.00
191.00	19100	RESEARCH	0	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	2,436	38,166	4,457	2,436	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)	0	13,570,838	534,852	3,909,489	1,117,143	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	50.843485	0.931650	17.289750	24.844171	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,732,992	7,457	331,359	216,602	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	10.239223	0.012989	1.465438	4.817017	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet B-1 | Date/Time Prepared: 11/18/2017 6:28 am

		Cost Center Description	CAFETERIA (ASSIGNED TIME)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,848,669					11.00
13.00	01300	NURSING ADMINISTRATION	28,158	553,148				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,254	0	1,000			14.00
15.00	01500	PHARMACY	85,802	0	0	1,000		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	94,547	0	0	0	1,280,308,030	16.00
17.00	01700	SOCIAL SERVICE	31,808	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	95,834	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	219,296	219,296	0	0	23,709,862	30.00
31.00	03100	INTENSIVE CARE UNIT	105,518	105,518	0	0	14,444,454	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	147,977	147,977	0	0	97,921,577	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96,113	0	0	0	52,698,717	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	51,478	0	0	0	83,210,340	55.00
56.00	05600	RADIOISOTOPE	8,427	0	0	0	5,955,564	56.00
57.00	05700	CT SCAN	14,405	0	0	0	89,469,643	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,008	0	0	0	22,795,343	58.00
60.00	06000	LABORATORY	100,681	0	0	0	81,252,990	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	7,566,415	63.00
64.00	06400	INTRAVENOUS THERAPY	50,595	50,595	0	0	35,056,452	64.00
65.00	06500	RESPIRATORY THERAPY	27,607	0	0	0	4,725,291	65.00
66.00	06600	PHYSICAL THERAPY	38,826	0	0	0	4,056,847	66.00
69.00	06900	ELECTROCARDIOLOGY	10,996	10,996	0	0	8,239,935	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,000	0	38,519,252	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	1,000	697,188,994	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	24,944	0	0	0	1,438,507	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	270,748	0	0	0	8,532,651	90.00
91.00	09100	EMERGENCY	18,766	18,766	0	0	3,525,196	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 1-117)	1,556,788	553,148	1,000	1,000	1,280,308,030	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	8,324	0	0	0	0	191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	283,557	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)	4,319,064	2,725,728	3,067,457	7,415,482	5,615,544	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.336310	4.927665	3,067.457000	7,415.482000	0.004386	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,038,606	96,818	1,069,459	675,766	327,504	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.561813	0.175031	1,069.459000	675.766000	0.000256	205.00

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		Cost Center Description	SOCIAL SERVICE (GROSS CHARGES)	OTHER GENERAL SERVICE (SPECIFY) (GROSS CHARGES)		
			17.00	18.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,280,308,030			17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	1,280,308,030		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	23,709,862	23,709,862		30.00
31.00	03100	INTENSIVE CARE UNIT	14,444,454	14,444,454		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	97,921,577	97,921,577		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,698,717	52,698,717		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	83,210,340	83,210,340		55.00
56.00	05600	RADIOISOTOPE	5,955,564	5,955,564		56.00
57.00	05700	CT SCAN	89,469,643	89,469,643		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	22,795,343	22,795,343		58.00
60.00	06000	LABORATORY	81,252,990	81,252,990		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,566,415	7,566,415		63.00
64.00	06400	INTRAVENOUS THERAPY	35,056,452	35,056,452		64.00
65.00	06500	RESPIRATORY THERAPY	4,725,291	4,725,291		65.00
66.00	06600	PHYSICAL THERAPY	4,056,847	4,056,847		66.00
69.00	06900	ELECTROCARDIOLOGY	8,239,935	8,239,935		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	38,519,252	38,519,252		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	697,188,994	697,188,994		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	1,438,507	1,438,507		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	8,532,651	8,532,651		90.00
91.00	09100	EMERGENCY	3,525,196	3,525,196		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 1-117)	1,280,308,030	1,280,308,030		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191.00	19100	RESEARCH	0	0		191.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	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)	1,726,862	7,037,003		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.001349	0.005496		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	150,497	500,546		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000118	0.000391		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/18/2017 6:28 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,095,089		23,095,089	0	23,095,089	30.00
31.00	03100	INTENSIVE CARE UNIT	10,299,346		10,299,346	0	10,299,346	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,958,801		17,958,801	0	17,958,801	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,860,077		11,860,077	0	11,860,077	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,143,514		12,143,514	0	12,143,514	55.00
56.00	05600	RADIOISOTOPE	1,097,378		1,097,378	0	1,097,378	56.00
57.00	05700	CT SCAN	2,652,624		2,652,624	0	2,652,624	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,818,353		2,818,353	0	2,818,353	58.00
60.00	06000	LABORATORY	12,468,477		12,468,477	0	12,468,477	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,780,313		1,780,313	0	1,780,313	63.00
64.00	06400	INTRAVENOUS THERAPY	5,657,277		5,657,277	0	5,657,277	64.00
65.00	06500	RESPIRATORY THERAPY	2,592,313	0	2,592,313	0	2,592,313	65.00
66.00	06600	PHYSICAL THERAPY	2,904,926	0	2,904,926	0	2,904,926	66.00
69.00	06900	ELECTROCARDIOLOGY	1,233,893		1,233,893	0	1,233,893	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,548,735		23,548,735	0	23,548,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,320,910		136,320,910	0	136,320,910	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,473,369		1,473,369	0	1,473,369	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,548,965		22,548,965	0	22,548,965	90.00
91.00	09100	EMERGENCY	2,057,739		2,057,739	0	2,057,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,743,335		3,743,335		3,743,335	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	298,255,434	0	298,255,434	0	298,255,434	200.00
201.00		Less Observation Beds	3,743,335		3,743,335		3,743,335	201.00
202.00		Total (see instructions)	294,512,099	0	294,512,099	0	294,512,099	202.00

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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	21,150,497		21,150,497			30.00
31.00	03100	INTENSIVE CARE UNIT	14,444,454		14,444,454			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,750,490	49,171,087	97,921,577	0.183400	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,510,272	46,188,445	52,698,717	0.225054	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,025,728	80,184,612	83,210,340	0.145938	0.000000	55.00
56.00	05600	RADIOISOTOPE	196,975	5,758,589	5,955,564	0.184261	0.000000	56.00
57.00	05700	CT SCAN	4,536,834	84,932,809	89,469,643	0.029648	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,777,678	21,017,665	22,795,343	0.123637	0.000000	58.00
60.00	06000	LABORATORY	15,422,065	65,830,925	81,252,990	0.153453	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,083,612	3,482,803	7,566,415	0.235291	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	152,585	34,903,867	35,056,452	0.161376	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,376,281	3,349,010	4,725,291	0.548604	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,093,675	1,963,172	4,056,847	0.716055	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,264,000	6,975,935	8,239,935	0.149745	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,756,207	17,763,045	38,519,252	0.611350	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,374,045	621,814,949	697,188,994	0.195529	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	147,590	1,290,917	1,438,507	1.024235	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,768	8,414,883	8,532,651	2.642668	0.000000	90.00
91.00	09100	EMERGENCY	1,102,617	2,422,579	3,525,196	0.583723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,066,055	1,493,310	2,559,365	1.462603	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	223,349,428	1,056,958,602	1,280,308,030			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	223,349,428	1,056,958,602	1,280,308,030			202.00

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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
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.183400		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225054		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145938		55.00
56.00	05600	RADIOISOTOPE	0.184261		56.00
57.00	05700	CT SCAN	0.029648		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123637		58.00
60.00	06000	LABORATORY	0.153453		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.235291		63.00
64.00	06400	INTRAVENOUS THERAPY	0.161376		64.00
65.00	06500	RESPIRATORY THERAPY	0.548604		65.00
66.00	06600	PHYSICAL THERAPY	0.716055		66.00
69.00	06900	ELECTROCARDIOLOGY	0.149745		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.611350		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195529		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951	HOSPITAL NUTRITION	1.024235		76.01
76.02	03952	PAIN MANAGEMENT	0.000000		76.02
76.03	03954	INFUSION CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	2.642668		90.00
91.00	09100	EMERGENCY	0.583723		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.462603		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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/18/2017 6:28 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,095,089		23,095,089	0	23,095,089	30.00
31.00	03100	INTENSIVE CARE UNIT	10,299,346		10,299,346	0	10,299,346	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,958,801		17,958,801	0	17,958,801	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,860,077		11,860,077	0	11,860,077	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	12,143,514		12,143,514	0	12,143,514	55.00
56.00	05600	RADIOISOTOPE	1,097,378		1,097,378	0	1,097,378	56.00
57.00	05700	CT SCAN	2,652,624		2,652,624	0	2,652,624	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,818,353		2,818,353	0	2,818,353	58.00
60.00	06000	LABORATORY	12,468,477		12,468,477	0	12,468,477	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,780,313		1,780,313	0	1,780,313	63.00
64.00	06400	INTRAVENOUS THERAPY	5,657,277		5,657,277	0	5,657,277	64.00
65.00	06500	RESPIRATORY THERAPY	2,592,313	0	2,592,313	0	2,592,313	65.00
66.00	06600	PHYSICAL THERAPY	2,904,926	0	2,904,926	0	2,904,926	66.00
69.00	06900	ELECTROCARDIOLOGY	1,233,893		1,233,893	0	1,233,893	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,548,735		23,548,735	0	23,548,735	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,320,910		136,320,910	0	136,320,910	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1,473,369		1,473,369	0	1,473,369	76.01
76.02	03952	PAIN MANAGEMENT	0		0	0	0	76.02
76.03	03954	INFUSION CENTER	0		0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	22,548,965		22,548,965	0	22,548,965	90.00
91.00	09100	EMERGENCY	2,057,739		2,057,739	0	2,057,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,743,335		3,743,335		3,743,335	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	298,255,434	0	298,255,434	0	298,255,434	200.00
201.00		Less Observation Beds	3,743,335		3,743,335		3,743,335	201.00
202.00		Total (see instructions)	294,512,099	0	294,512,099	0	294,512,099	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/18/2017 6:28 am

Title XIX | Hospital | Cost

		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	21,150,497		21,150,497			30.00
31.00	03100	INTENSIVE CARE UNIT	14,444,454		14,444,454			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0		0			34.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,750,490	49,171,087	97,921,577	0.183400	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,510,272	46,188,445	52,698,717	0.225054	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,025,728	80,184,612	83,210,340	0.145938	0.000000	55.00
56.00	05600	RADIOISOTOPE	196,975	5,758,589	5,955,564	0.184261	0.000000	56.00
57.00	05700	CT SCAN	4,536,834	84,932,809	89,469,643	0.029648	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,777,678	21,017,665	22,795,343	0.123637	0.000000	58.00
60.00	06000	LABORATORY	15,422,065	65,830,925	81,252,990	0.153453	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,083,612	3,482,803	7,566,415	0.235291	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	152,585	34,903,867	35,056,452	0.161376	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,376,281	3,349,010	4,725,291	0.548604	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,093,675	1,963,172	4,056,847	0.716055	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	1,264,000	6,975,935	8,239,935	0.149745	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,756,207	17,763,045	38,519,252	0.611350	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,374,045	621,814,949	697,188,994	0.195529	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.01	03951	HOSPITAL NUTRITION	147,590	1,290,917	1,438,507	1.024235	0.000000	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0.000000	0.000000	76.02
76.03	03954	INFUSION CENTER	0	0	0	0.000000	0.000000	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	117,768	8,414,883	8,532,651	2.642668	0.000000	90.00
91.00	09100	EMERGENCY	1,102,617	2,422,579	3,525,196	0.583723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,066,055	1,493,310	2,559,365	1.462603	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	223,349,428	1,056,958,602	1,280,308,030			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	223,349,428	1,056,958,602	1,280,308,030			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet C Part I Date/Time Prepared: 11/18/2017 6:28 am

Title XIX | Hospital | Cost

		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
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000		76.00
76.01	03951	HOSPITAL NUTRITION	0.000000		76.01
76.02	03952	PAIN MANAGEMENT	0.000000		76.02
76.03	03954	INFUSION CENTER	0.000000		76.03
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		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: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part I Date/Time Prepared: 11/18/2017 6:28 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	3,209,688	0	3,209,688	6,546	490.33	30.00
31.00	INTENSIVE CARE UNIT	1,385,521		1,385,521	5,090	272.20	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0		0	0	0.00	34.00
200.00	Total (lines 30-199)	4,595,209		4,595,209	11,636		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	880	431,490	30.00
31.00	INTENSIVE CARE UNIT	358	97,448	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	0	0	34.00
200.00	Total (lines 30-199)	1,238	528,938	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part II Date/Time Prepared: 11/18/2017 6:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,417,678	97,921,577	0.034902	4,546,693	158,689	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,421,682	52,698,717	0.045953	898,984	41,311	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,816,178	83,210,340	0.033844	307,300	10,400	55.00
56.00	05600	RADIOISOTOPE	209,524	5,955,564	0.035181	19,916	701	56.00
57.00	05700	CT SCAN	340,172	89,469,643	0.003802	661,821	2,516	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,014,085	22,795,343	0.044486	224,922	10,006	58.00
60.00	06000	LABORATORY	1,003,060	81,252,990	0.012345	1,917,218	23,668	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	207,192	7,566,415	0.027383	413,029	11,310	63.00
64.00	06400	INTRAVENOUS THERAPY	713,840	35,056,452	0.020363	4,522	92	64.00
65.00	06500	RESPIRATORY THERAPY	203,390	4,725,291	0.043043	205,816	8,859	65.00
66.00	06600	PHYSICAL THERAPY	201,393	4,056,847	0.049643	290,653	14,429	66.00
69.00	06900	ELECTROCARDIOLOGY	156,939	8,239,935	0.019046	264,662	5,041	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,372,708	38,519,252	0.035637	2,227,248	79,372	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,861,568	697,188,994	0.004104	7,026,237	28,836	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	74,106	1,438,507	0.051516	18,590	958	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,616,165	8,532,651	0.306606	11,259	3,452	90.00
91.00	09100	EMERGENCY	200,878	3,525,196	0.056983	174,719	9,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	520,237	2,559,365	0.203268	127,470	25,911	92.00
200.00		Total (lines 50-199)	20,350,795	1,244,713,079		19,341,059	435,507	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part III Date/Time Prepared: 11/18/2017 6:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		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	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		0	34.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,546	0.00	880	0		30.00
31.00	03100	INTENSIVE CARE UNIT	5,090	0.00	358	0		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0.00	0	0		34.00
200.00		Total (lines 30-199)	11,636		1,238	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV | Date/Time Prepared: 11/18/2017 6:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0	0	0	0	0	76.03
		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 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/18/2017 6:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	97,921,577	0.000000	0.000000	4,546,693	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	52,698,717	0.000000	0.000000	898,984	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	83,210,340	0.000000	0.000000	307,300	55.00
56.00	05600	RADIOISOTOPE	0	5,955,564	0.000000	0.000000	19,916	56.00
57.00	05700	CT SCAN	0	89,469,643	0.000000	0.000000	661,821	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,795,343	0.000000	0.000000	224,922	58.00
60.00	06000	LABORATORY	0	81,252,990	0.000000	0.000000	1,917,218	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	7,566,415	0.000000	0.000000	413,029	63.00
64.00	06400	INTRAVENOUS THERAPY	0	35,056,452	0.000000	0.000000	4,522	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,725,291	0.000000	0.000000	205,816	65.00
66.00	06600	PHYSICAL THERAPY	0	4,056,847	0.000000	0.000000	290,653	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,239,935	0.000000	0.000000	264,662	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	38,519,252	0.000000	0.000000	2,227,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	697,188,994	0.000000	0.000000	7,026,237	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.01	03951	HOSPITAL NUTRITION	0	1,438,507	0.000000	0.000000	18,590	76.01
76.02	03952	PAIN MANAGEMENT	0	0	0.000000	0.000000	0	76.02
76.03	03954	INFUSION CENTER	0	0	0.000000	0.000000	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,532,651	0.000000	0.000000	11,259	90.00
91.00	09100	EMERGENCY	0	3,525,196	0.000000	0.000000	174,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,559,365	0.000000	0.000000	127,470	92.00
200.00		Total (lines 50-199)	0	1,244,713,079			19,341,059	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part IV Date/Time Prepared: 11/18/2017 6:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	5,430,980	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,825,665	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,058,810	0		55.00
56.00	05600	RADIOISOTOPE	0	613,574	0		56.00
57.00	05700	CT SCAN	0	12,228,388	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,802,888	0		58.00
60.00	06000	LABORATORY	0	6,938,817	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	268,808	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	4,007,742	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	412,398	0		65.00
66.00	06600	PHYSICAL THERAPY	0	510	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	834,413	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,284,478	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	59,909,957	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0	0		76.02
76.03	03954	INFUSION CENTER	0	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	1,087,899	0		90.00
91.00	09100	EMERGENCY	0	289,896	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	135,420	0		92.00
200.00		Total (lines 50-199)	0	111,130,643	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/18/2017 6:28 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	0.183400	5,430,980	0	0	996,042	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225054	5,825,665	0	0	1,311,089	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145938	9,058,810	0	0	1,322,025	55.00
56.00	05600	RADIOISOTOPE	0.184261	613,574	0	0	113,058	56.00
57.00	05700	CT SCAN	0.029648	12,228,388	0	0	362,547	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123637	2,802,888	0	0	346,541	58.00
60.00	06000	LABORATORY	0.153453	6,938,817	2,216	0	1,064,782	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.235291	268,808	0	0	63,248	63.00
64.00	06400	INTRAVENOUS THERAPY	0.161376	4,007,742	13	0	646,753	64.00
65.00	06500	RESPIRATORY THERAPY	0.548604	412,398	7	0	226,243	65.00
66.00	06600	PHYSICAL THERAPY	0.716055	510	0	0	365	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149745	834,413	0	0	124,949	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.611350	1,284,478	0	0	785,266	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	0.195529	59,909,957	0	173,200	11,714,134	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.024235	0	0	0	0	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2.642668	1,087,899	1,160	1,813	2,874,956	90.00
91.00	09100	EMERGENCY	0.583723	289,896	0	0	169,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.462603	135,420	0	0	198,066	92.00
200.00		Subtotal (see instructions)		111,130,643	3,396	175,013	22,319,283	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		111,130,643	3,396	175,013	22,319,283	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D Part V Date/Time Prepared: 11/18/2017 6:28 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	340	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	2	0		64.00
65.00	06500	RESPIRATORY THERAPY	4	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	33,866		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.01	03951	HOSPITAL NUTRITION	0	0		76.01
76.02	03952	PAIN MANAGEMENT	0	0		76.02
76.03	03954	INFUSION CENTER	0	0		76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	3,065	4,791		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)	3,411	38,657		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,411	38,657		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0100	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/18/2017 6:28 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)	6,546	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,546	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)	5,485	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)	880	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	23,095,089	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	23,095,089	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	23,095,089	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)	3,528.12	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,104,746	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,104,746	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/18/2017 6:28 am

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	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	10,299,346	5,090	2,023.45	358	724,395	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	4,957,594	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,786,735	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)	528,938	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	435,507	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	964,445	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,822,290	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)	1,061	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,528.12	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,743,335	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-1 | Date/Time Prepared: 11/18/2017 6:28 am

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	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	3,209,688	23,095,089	0.138977	3,743,335	520,237	90.00
91.00	Nursing School cost	0	23,095,089	0.000000	3,743,335	0	91.00
92.00	Allied health cost	0	23,095,089	0.000000	3,743,335	0	92.00
93.00	All other Medical Education	0	23,095,089	0.000000	3,743,335	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet D-3 | Date/Time Prepared: 11/18/2017 6:28 am

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		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		1,881,637		30.00
31.00	03100	INTENSIVE CARE UNIT		1,785,564		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0		34.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.183400	4,546,693	833,863	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.225054	898,984	202,320	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.145938	307,300	44,847	55.00
56.00	05600	RADIOISOTOPE	0.184261	19,916	3,670	56.00
57.00	05700	CT SCAN	0.029648	661,821	19,622	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.123637	224,922	27,809	58.00
60.00	06000	LABORATORY	0.153453	1,917,218	294,203	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.235291	413,029	97,182	63.00
64.00	06400	INTRAVENOUS THERAPY	0.161376	4,522	730	64.00
65.00	06500	RESPIRATORY THERAPY	0.548604	205,816	112,911	65.00
66.00	06600	PHYSICAL THERAPY	0.716055	290,653	208,124	66.00
69.00	06900	ELECTROCARDIOLOGY	0.149745	264,662	39,632	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.611350	2,227,248	1,361,628	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.195529	7,026,237	1,373,833	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.01	03951	HOSPITAL NUTRITION	1.024235	18,590	19,041	76.01
76.02	03952	PAIN MANAGEMENT	0.000000	0	0	76.02
76.03	03954	INFUSION CENTER	0.000000	0	0	76.03
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	2.642668	11,259	29,754	90.00
91.00	09100	EMERGENCY	0.583723	174,719	101,987	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.462603	127,470	186,438	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		19,341,059	4,957,594	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)		19,341,059		202.00

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		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)	526,841	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1,830,644	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)	1,822,177	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)	70.09	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 Section 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 section 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 section 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 Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.00	30.00
31.00	Percentage of Medicaid patient days (see instructions)	0.00	31.00
32.00	Sum of lines 30 and 31	0.00	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		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)	4,179,662		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		4,179,662	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		398,440	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)		4,578,102	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,578,102	61.00
62.00	Deductibles billed to program beneficiaries		183,792	62.00
63.00	Coinsurance billed to program beneficiaries		7,728	63.00
64.00	Allowable bad debts (see instructions)		7,624	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		4,956	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,391,538	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 DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		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)		43,719	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		46,218	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,389,039	71.00
71.01	Sequestration adjustment (see instructions)		87,781	71.01
72.00	Interim payments		4,299,850	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, 72, and 73)		1,408	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/18/2017 6:28 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	526,841	526,841		526,841	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,830,644		1,830,644	1,830,644	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,822,177	372,243	1,449,934	1,822,177	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	4,179,662	899,084	3,280,578	4,179,662	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	4,179,662	899,084	3,280,578	4,179,662	15.00
16.00	Payment for inpatient program capital	50.00	398,440	79,757	318,683	398,440	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			978,841	3,599,261	4,578,102	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/18/2017 6:28 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	190,421	42,249	148,172	190,421	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	208,019	37,508	170,511	208,019	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	398,440	79,757	318,683	398,440	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	43,719	8,060	35,659	43,719	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		9,869	36,349	46,218	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	42,068	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	22,319,283	2.00
3.00	PPS payments	13,797,726	3.00
4.00	Outlier payment (see instructions)	300,014	4.00
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 line 3 plus line 4 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)	42,068	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	178,409	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)	178,409	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)	178,409	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	136,341	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) (for CAH see instructions)	42,068	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, 8 and 9)	14,097,740	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)	2,394,657	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)	11,745,151	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)	11,745,151	30.00
31.00	Primary payer payments	1,408	31.00
32.00	Subtotal (line 30 minus line 31)	11,743,743	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)	200,601	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	130,391	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	11,874,134	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-226	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	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)	11,874,360	40.00
40.01	Sequestration adjustment (see instructions)	237,487	40.01
41.00	Interim payments	11,566,996	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	69,877	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet E-1 Part I Date/Time Prepared: 11/18/2017 6:28 am

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		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		4,299,850		11,566,996	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)		4,299,850		11,566,996	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		1,408		69,877	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,301,258		11,636,873	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: 14-0100	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/18/2017 6:28 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	1,929	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,238	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	95	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	10,575	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,280,308,030	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	23,811,538	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	69,208	8.00
9.00	Sequestration adjustment amount (see instructions)	1,384	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	67,824	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	67,824	32.00

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

Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G | Date/Time Prepared: 11/18/2017 6:28 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	0	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	0	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	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)	0	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	0	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	0	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	0	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	0	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	0	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	0				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)	0	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	0	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-1 | Date/Time Prepared: 11/18/2017 6:28 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		0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-541,561,129				2.00
3.00	Total (sum of line 1 and line 2)		-541,561,129		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		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)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		-541,561,129		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-541,561,129		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/18/2017 6:28 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	0		0	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	0		0	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	0		0	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	0	0	0	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		541,561,129		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)		541,561,129		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0100 | Period: From 07/01/2016 To 06/30/2017 | Worksheet G-3 | Date/Time Prepared: 11/18/2017 6:28 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	0	1.00
2.00	Less contractual allowances and discounts on patients' accounts	0	2.00
3.00	Net patient revenues (line 1 minus line 2)	0	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	541,561,129	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-541,561,129	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	0	25.00
26.00	Total (line 5 plus line 25)	-541,561,129	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-541,561,129	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0100	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/18/2017 6:28 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	190,421	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	208,019	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)	28.97	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)	398,440	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