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: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/24/2018 5:09 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2018 Time: 5:09 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by METROSOUTH MEDICAL CENTER (14-0118) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	850,169	-40,977	0	0	1.00
2.00	Subprovider - IPF	0	17,700	12		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	867,869	-40,965	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 12935 SOUTH GREGORY STREET	PO Box:			1.00
2.00	City: BLUE ISLAND	State: IL	Zip Code: 60406	County: COOK	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	METROSOUTH MEDICAL CENTER	140118	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	METRO SOUTH PSYCH UNIT	14S118	16974	4	01/01/2013	N	P	O	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)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,396	1,193	3	13	8,533	412	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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 5:05 pm

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

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 5:05 pm

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	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:	108,438	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0776	140.00

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	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: QUORUM HEALTH CORPORATION	Contractor's Name: WPS	Contractor's Number: 52280	141.00
142.00	Street: 1573 MALLORY LAND	PO Box: SUITE 100		142.00
143.00	City: BRENTWOOD	State: TN	Zip Code: 37027	143.00

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	06/14/2017	09/11/2017	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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2018 5:05 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	03/16/2018	Y	03/16/2018	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)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 5:05 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AMBER		WALKER		41.00
42.00	Enter the employer/company name of the cost report preparer.	QHR				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615.221.3646		AMBER_WALKER@QUORUMHEALTH.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 5:05 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2018 5:05 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	264	96,360	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)		264	96,360	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	34	12,410	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		298	108,770	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
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)		312				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

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	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,716	1,519	25,662			1.00
2.00	HMO and other (see instructions)	4,946	8,086				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)	8,716	1,519	25,662			7.00
8.00	INTENSIVE CARE UNIT	973	84	2,760			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		2,449	4,048			13.00
14.00	Total (see instructions)	9,689	4,052	32,470	0.00	645.44	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,993	0	3,748	0.00	21.69	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	667.13	27.00
28.00	Observation Bed Days		0	3,104			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	412	518			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,010	2,943	8,005	1.00
2.00	HMO and other (see instructions)			974	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	2,010	2,943	8,005	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	209	0	399	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			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2018 5:05 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	47,553,289	0	47,553,289	1,387,625.83	34.27	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)		1,427,234	209,316	1,636,550	51,137.48	32.00	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,710,730	0	1,710,730	26,399.95	64.80	11.00
12.00	Contract labor: Top level management and other management and administrative services		21,250	0	21,250	250.00	85.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		681,673	0	681,673	2,142.45	318.17	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		1,085,756	0	1,085,756	16,926.00	64.15	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)		9,648,915	0	9,648,915			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		366,004	0	366,004			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 (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	399,884	0	399,884	10,251.75	39.01	26.00
27.00	Administrative & General	5.00	5,086,483	-487,365	4,599,118	149,893.46	30.68	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2018 5:05 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		505,341	0	505,341	5,510.00	91.71	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,192,676	0	1,192,676	30,098.85	39.63	30.00
31.00	Laundry & Linen Service	8.00	46,268	0	46,268	2,359.00	19.61	31.00
32.00	Housekeeping	9.00	545,006	0	545,006	31,133.75	17.51	32.00
33.00	Housekeeping under contract (see instructions)		2,130,335	0	2,130,335	107,484.00	19.82	33.00
34.00	Dietary	10.00	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)		2,144,611	0	2,144,611	88,657.50	24.19	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,267,481	278,049	2,545,530	51,782.25	49.16	38.00
39.00	Central Services and Supply	14.00	468,390	0	468,390	22,568.53	20.75	39.00
40.00	Pharmacy	15.00	1,695,407	0	1,695,407	38,996.75	43.48	40.00
41.00	Medical Records & Medical Records Library	16.00	493,331	0	493,331	20,781.75	23.74	41.00
42.00	Social Service	17.00	2,020	0	2,020	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2018 5:05 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		52,333,576	0	52,333,576	1,589,277.33	32.93	1.00
2.00	Excluded area salaries (see instructions)		1,427,234	209,316	1,636,550	51,137.48	32.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		50,906,342	-209,316	50,697,026	1,538,139.85	32.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		3,499,409	0	3,499,409	45,718.40	76.54	4.00
5.00	Subtotal wage-related costs (see inst.)		9,648,915	0	9,648,915	0.00	19.03	5.00
6.00	Total (sum of lines 3 thru 5)		64,054,666	-209,316	63,845,350	1,583,858.25	40.31	6.00
7.00	Total overhead cost (see instructions)		16,977,233	-209,316	16,767,917	559,517.59	29.97	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2018 5:05 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	936,174	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)	4,248,635	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	147,236	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	34,929	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	485	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	139,131	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	542,977	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,769,700	17.00
18.00	Medicare Taxes - Employers Portion Only	647,753	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	530,005	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	17,893	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,014,918	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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/24/2018 5:05 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,710,730	10,014,918	1.00
2.00	Hospital	1,710,730	10,014,918	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/24/2018 5:05 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.142986	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	18,726,056	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	16,140,964	5.00
6.00	Medicaid charges	257,557,844	6.00
7.00	Medicaid cost (line 1 times line 6)	36,827,166	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,960,146	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	11,741	9.00
10.00	Stand-alone CHIP charges	145,647	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	20,825	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	9,084	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,969,230	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)	24,322,403	140,802	24,463,205	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,477,763	140,802	3,618,565	21.00
22.00	Payments received from patients for amounts previously written off as charity care	56,384	0	56,384	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,421,379	140,802	3,562,181	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	10,557,711	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	622,018	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	956,950	27.01
28.00	Non-Medicare bad debt expense (see instructions)	9,600,761	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,707,706	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,269,887	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	7,239,117	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,518,559	1,518,559	1,017,724	2,536,283	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,294,964	4,294,964	1,783,973	6,078,937	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	399,884	295,866	695,750	6,062,209	6,757,959	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,086,483	32,532,653	37,619,136	-7,839,442	29,779,694	5.00
7.00	00700	OPERATION OF PLANT	1,192,676	4,526,395	5,719,071	-622	5,718,449	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,268	743,237	789,505	0	789,505	8.00
9.00	00900	HOUSEKEEPING	545,006	2,480,491	3,025,497	0	3,025,497	9.00
10.00	01000	DIETARY	0	2,537,962	2,537,962	-724	2,537,238	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,267,481	486,679	2,754,160	264,469	3,018,629	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	468,390	8,262,367	8,730,757	-7,679,013	1,051,744	14.00
15.00	01500	PHARMACY	1,695,407	3,469,895	5,165,302	-3,314,644	1,850,658	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	493,331	1,514,628	2,007,959	0	2,007,959	16.00
17.00	01700	SOCIAL SERVICE	2,020	191	2,211	0	2,211	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,163,999	3,201,424	14,365,423	-36,284	14,329,139	30.00
31.00	03100	INTENSIVE CARE UNIT	3,176,912	2,045,533	5,222,445	-119,023	5,103,422	31.00
40.00	04000	SUBPROVIDER - IPF	1,372,765	521,499	1,894,264	-2,737	1,891,527	40.00
43.00	04300	NURSERY	487,513	353,402	840,915	-5,678	835,237	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,059,605	4,166,085	7,225,690	-1,841,954	5,383,736	50.00
51.00	05100	RECOVERY ROOM	708,846	77,233	786,079	0	786,079	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,990,645	2,064,648	4,055,293	-11,520	4,043,773	52.00
53.00	05300	ANESTHESIOLOGY	82,131	914,879	997,010	0	997,010	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,727,879	1,247,796	2,975,675	0	2,975,675	54.00
54.01	05401	ULTRASOUND	509,356	112,333	621,689	0	621,689	54.01
56.00	05600	RADIOISOTOPE	233,752	419,406	653,158	0	653,158	56.00
57.00	05700	CT SCAN	615,523	239,051	854,574	0	854,574	57.00
58.00	05800	MRI	223,817	130,947	354,764	0	354,764	58.00
60.00	06000	LABORATORY	2,457,348	2,861,934	5,319,282	-42,050	5,277,232	60.00
65.00	06500	RESPIRATORY THERAPY	934,707	375,546	1,310,253	-135,174	1,175,079	65.00
66.00	06600	PHYSICAL THERAPY	828,657	98,065	926,722	-112,884	813,838	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,581	7,787	85,368	32,472	117,840	67.00
68.00	06800	SPEECH PATHOLOGY	183,113	41,165	224,278	63,115	287,393	68.00
69.00	06900	ELECTROCARDIOLOGY	1,916,405	1,303,178	3,219,583	-8,767	3,210,816	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,477,190	2,477,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,872,074	5,872,074	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,109,940	3,109,940	73.00
74.00	07400	RENAL DIALYSIS	0	951,100	951,100	0	951,100	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	45,043	6,190	51,233	0	51,233	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,506,277	3,627,738	7,134,015	-7,092	7,126,923	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,498,820	87,430,826	134,929,646	-474,442	134,455,204	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,878	12,878	0	12,878	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	474,442	474,442	194.01
194.02	07953	SENIOR CIRCLE	54,469	17,186	71,655	0	71,655	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	47,553,289	87,460,890	135,014,179	0	135,014,179	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-525,454	2,010,829		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	377,699	6,456,636		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-23,811	6,734,148		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-13,765,879	16,013,815		5.00
7.00	00700	OPERATION OF PLANT	0	5,718,449		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	789,505		8.00
9.00	00900	HOUSEKEEPING	0	3,025,497		9.00
10.00	01000	DIETARY	0	2,537,238		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	-33,755	2,984,874		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,051,744		14.00
15.00	01500	PHARMACY	0	1,850,658		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,481	2,006,478		16.00
17.00	01700	SOCIAL SERVICE	0	2,211		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,132,649	13,196,490		30.00
31.00	03100	INTENSIVE CARE UNIT	-791,425	4,311,997		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,891,527		40.00
43.00	04300	NURSERY	-93,417	741,820		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-41,300	5,342,436		50.00
51.00	05100	RECOVERY ROOM	0	786,079		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,251,300	2,792,473		52.00
53.00	05300	ANESTHESIOLOGY	-770,626	226,384		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,975,675		54.00
54.01	05401	ULTRASOUND	0	621,689		54.01
56.00	05600	RADIOISOTOPE	-30,030	623,128		56.00
57.00	05700	CT SCAN	0	854,574		57.00
58.00	05800	MRI	0	354,764		58.00
60.00	06000	LABORATORY	-25,200	5,252,032		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,175,079		65.00
66.00	06600	PHYSICAL THERAPY	0	813,838		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	117,840		67.00
68.00	06800	SPEECH PATHOLOGY	0	287,393		68.00
69.00	06900	ELECTROCARDIOLOGY	-38,325	3,172,491		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,477,190		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,872,074		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-855	3,109,085		73.00
74.00	07400	RENAL DIALYSIS	0	951,100		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	51,233		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,755,954	5,370,969		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-19,903,762	114,551,442		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	12,878		192.00
194.00	07950	CHF CLINIC	0	0		194.00
194.01	07951	MARKETING	0	474,442		194.01
194.02	07953	SENIOR CIRCLE	-25	71,630		194.02
194.03	07952	MOB	0	0		194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-19,903,787	115,110,392		200.00

RECLASSIFICATIONS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 5:05 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,062,209	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	6,062,209	
	B - OXYGEN COSTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	60,648	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	60,648	
	C - RENTAL AND LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	235,054	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,777,186	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	2,012,240	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	187,159	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,787	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	595,511	3.00
	0		0	789,457	
	E - MARKETING DEPARTMENT				
1.00	MARKETING	194.01	209,316	265,126	1.00
	0		209,316	265,126	
	F - CHIEF NURSING OFFICER				
1.00	NURSING ADMINISTRATION	13.00	278,049	0	1.00
	0		278,049	0	
	G - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,416,542	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,872,074	2.00
3.00		0.00	0	0	3.00
	0		0	8,288,616	
	H - COSTS OF DRUGS/IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,109,940	1.00
	0		0	3,109,940	
	I - PT, OT, SP COSTS				
1.00	OCCUPATIONAL THERAPY	67.00	26,320	6,152	1.00
2.00	SPEECH PATHOLOGY	68.00	81,236	0	2.00
	0		107,556	6,152	
500.00	Grand Total: Increases		594,921	20,594,388	500.00

RECLASSIFICATIONS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 5:05 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,057,824	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	4,280	0		2.00
3.00	PHARMACY	15.00	0	105	0		3.00
	0		0	6,062,209			
	B - OXYGEN COSTS						
1.00	OPERATION OF PLANT	7.00	0	455	0		1.00
2.00	OPERATING ROOM	50.00	0	52	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	60,141	0		3.00
	0		0	60,648			
	C - RENTAL AND LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	239,670	10		1.00
2.00	OPERATION OF PLANT	7.00	0	167	10		2.00
3.00	DIETARY	10.00	0	724	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	9,300	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	826,711	0		5.00
6.00	PHARMACY	15.00	0	204,599	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	36,284	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	119,023	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	2,737	0		9.00
10.00	NURSERY	43.00	0	5,678	0		10.00
11.00	OPERATING ROOM	50.00	0	411,654	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,520	0		12.00
13.00	LABORATORY	60.00	0	42,050	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	75,033	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	4,011	0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	13,286	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	2,701	0		17.00
18.00	EMERGENCY	91.00	0	7,092	0		18.00
	0		0	2,012,240			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	789,457	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	0		0	789,457			
	E - MARKETING DEPARTMENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	209,316	265,126	0		1.00
	0		209,316	265,126			
	F - CHIEF NURSING OFFICER						
1.00	ADMINISTRATIVE & GENERAL	5.00	278,049	0	0		1.00
	0		278,049	0			
	G - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,852,302	0		1.00
2.00	OPERATING ROOM	50.00	0	1,430,248	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	6,066	0		3.00
	0		0	8,288,616			
	H - COSTS OF DRUGS/IV SOLUTIONS						
1.00	PHARMACY	15.00	0	3,109,940	0		1.00
	0		0	3,109,940			
	I - PT, OT, SP COSTS						
1.00	PHYSICAL THERAPY	66.00	107,556	1,317	0		1.00
2.00	SPEECH PATHOLOGY	68.00	0	4,835	0		2.00
	0		107,556	6,152			
500.00	Grand Total: Decreases		594,921	20,594,388			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

		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	13,700	29,575	0	29,575	0	2.00
3.00	Buildings and Fixtures	95,004	1,809	0	1,809	0	3.00
4.00	Building Improvements	7,797,521	97,346	0	97,346	7,803	4.00
5.00	Fixed Equipment	2,091,690	21,165	0	21,165	0	5.00
6.00	Movable Equipment	22,101,169	425,830	0	425,830	28,514	6.00
7.00	HIT designated Assets	14,119,204	0	0	0	63,708	7.00
8.00	Subtotal (sum of lines 1-7)	46,218,288	575,725	0	575,725	100,025	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	46,218,288	575,725	0	575,725	100,025	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	43,275	0	2.00
3.00	Buildings and Fixtures	96,813	0	3.00
4.00	Building Improvements	7,887,064	0	4.00
5.00	Fixed Equipment	2,112,855	0	5.00
6.00	Movable Equipment	22,498,485	0	6.00
7.00	HIT designated Assets	14,055,496	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,693,988	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	46,693,988	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2018 5:05 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,518,559	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,103,852	191,112	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,622,411	191,112	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,518,559		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,294,964		2.00
3.00	Total (sum of lines 1-2)	0	5,813,523		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2018 5:05 pm

	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	10,140,007	0	10,140,007	0.217159	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	36,553,981	0	36,553,981	0.782841	0	2.00
3.00	Total (sum of lines 1-2)	46,693,988	0	46,693,988	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	1,240,867	-12,708	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,316,174	2,133,675	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,557,041	2,120,967	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	0	782,670	0	0	2,010,829	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	6,787	0	6,456,636	2.00
3.00	Total (sum of lines 1-2)	0	782,670	6,787	0	8,467,465	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 5:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-180,400	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-63,294	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,962,600			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	-3,916,086			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-855	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,481	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-277,692	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	225,760	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INSERVICE EDUCATION	B	-490	NURSING ADMINISTRATION	13.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 5:05 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	A&G OTHER INCOME	B	-291,209	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	RENTAL INCOME	B	-247,762	CAP REL COSTS-BLDG & FIXT	1.00	10	33.02
33.03	MARKETING EXPENSE	A	-25	SENIOR CIRCLE	194.02	0	33.03
33.04	PATIENT TELEPHONE COSTS - BENEFITS	A	-10,447	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	MARKETING EXPENSE	A	-270,479	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	LOBBYING EXPENSE	A	-75,582	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PROVIDER TAX	A	-8,570,887	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	PHYSICIAN RECRUITING	A	-161,000	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PATIENT TELEPHONE & TV DEPRECIATION	A	-13,438	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.09
33.10	SPECIAL EVENTS	A	-840	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.11
33.12	MARKETING EXPENSE	A	-13,364	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.34	LOST CHARGES	A	-892	ADULTS & PEDIATRICS	30.00	0	33.34
33.35	OTHER NON-ALLOWABLE COST	A	-70,724	ADMINISTRATIVE & GENERAL	5.00	0	33.35
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,903,787				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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2018 5:05 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HO CAPITAL COSTS - MOVABLE E	165,377	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HO COSTS	2,959,829	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	5,196,954	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	CIG LEASED EXPENSE	146,547	191,112	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE ALLOCATIONS	109,436	1,909,209	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,381,189	7,297,275	5.00

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

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

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

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

6.00	B	QUORUM HELATH	100.00	QHR	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/24/2018 5:05 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	165,377	10		1.00
2.00	2,959,829	0		2.00
3.00	-5,196,954	0		3.00
4.00	-44,565	0		4.00
4.01	-1,799,773	0		4.01
5.00	-3,916,086			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2018 5:05 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	41,236	1	41,235	177,200	570	1.00
2.00	13.00	NURSING ADMINISTRATION	48,600	0	48,600	177,200	180	2.00
3.00	30.00	ADULTS & PEDIATRICS	1,159,189	1,103,599	55,590	177,200	322	3.00
4.00	31.00	INTENSIVE CARE UNIT	791,425	791,425	0	0	0	4.00
5.00	43.00	NURSERY	93,417	93,417	0	0	0	5.00
6.00	50.00	OPERATING ROOM	41,300	41,300	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	1,251,300	1,251,300	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	770,626	770,626	0	0	0	8.00
9.00	56.00	RADIOISOTOPE	30,030	30,030	0	0	0	9.00
10.00	60.00	LABORATORY	25,200	25,200	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	38,325	38,325	0	0	0	11.00
12.00	91.00	EMERGENCY	1,755,954	1,755,954	0	0	0	12.00
200.00			6,046,602	5,901,177	145,425		1,072	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	48,560	2,428	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	15,335	767	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	27,432	1,372	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	43.00	NURSERY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	56.00	RADIOISOTOPE	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	0	0	0	0	0	12.00
200.00			91,327	4,567	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	48,560	0	1		1.00
2.00	13.00	NURSING ADMINISTRATION	0	15,335	33,265	33,265		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	27,432	28,158	1,131,757		3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	791,425		4.00
5.00	43.00	NURSERY	0	0	0	93,417		5.00
6.00	50.00	OPERATING ROOM	0	0	0	41,300		6.00
7.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,251,300		7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	770,626		8.00
9.00	56.00	RADIOISOTOPE	0	0	0	30,030		9.00
10.00	60.00	LABORATORY	0	0	0	25,200		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	0	0	38,325		11.00
12.00	91.00	EMERGENCY	0	0	0	1,755,954		12.00
200.00			0	91,327	61,423	5,962,600		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,010,829	2,010,829				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	6,456,636		6,456,636			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,734,148	12,203	39,969	6,786,320		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,013,815	200,764	657,543	661,905	17,534,027	5.00
7.00	00700	OPERATION OF PLANT	5,718,449	318,575	1,043,397	171,650	7,252,071	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	789,505	63,392	207,621	6,659	1,067,177	8.00
9.00	00900	HOUSEKEEPING	3,025,497	0	0	78,437	3,103,934	9.00
10.00	01000	DIETARY	2,537,238	49,021	160,554	0	2,746,813	10.00
11.00	01100	CAFETERIA	0	44,813	146,770	0	191,583	11.00
13.00	01300	NURSING ADMINISTRATION	2,984,874	4,979	16,308	366,353	3,372,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,051,744	30,090	98,551	67,411	1,247,796	14.00
15.00	01500	PHARMACY	1,850,658	14,211	46,545	244,003	2,155,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,006,478	16,012	52,442	71,000	2,145,932	16.00
17.00	01700	SOCIAL SERVICE	2,211	0	0	291	2,502	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,196,490	263,452	862,859	1,606,724	15,929,525	30.00
31.00	03100	INTENSIVE CARE UNIT	4,311,997	53,845	176,353	457,221	4,999,416	31.00
40.00	04000	SUBPROVIDER - IPF	1,891,527	32,817	107,481	197,568	2,229,393	40.00
43.00	04300	NURSERY	741,820	20,013	65,547	70,163	897,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,342,436	167,911	549,940	440,338	6,500,625	50.00
51.00	05100	RECOVERY ROOM	786,079	19,265	63,096	102,017	970,457	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,792,473	31,902	104,484	286,494	3,215,353	52.00
53.00	05300	ANESTHESIOLOGY	226,384	0	0	11,820	238,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,975,675	67,263	220,301	248,676	3,511,915	54.00
54.01	05401	ULTRASOUND	621,689	0	0	73,307	694,996	54.01
56.00	05600	RADIOISOTOPE	623,128	10,418	34,120	33,642	701,308	56.00
57.00	05700	CT SCAN	854,574	20,187	66,117	88,586	1,029,464	57.00
58.00	05800	MRI	354,764	3,853	12,619	32,212	403,448	58.00
60.00	06000	LABORATORY	5,252,032	53,304	174,581	353,662	5,833,579	60.00
65.00	06500	RESPIRATORY THERAPY	1,175,079	14,734	48,256	134,523	1,372,592	65.00
66.00	06600	PHYSICAL THERAPY	813,838	41,390	135,559	103,781	1,094,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	117,840	0	0	14,953	132,793	67.00
68.00	06800	SPEECH PATHOLOGY	287,393	0	0	38,045	325,438	68.00
69.00	06900	ELECTROCARDIOLOGY	3,172,491	186,923	612,211	275,809	4,247,434	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,477,190	0	0	0	2,477,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,872,074	0	0	0	5,872,074	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,109,085	0	0	0	3,109,085	73.00
74.00	07400	RENAL DIALYSIS	951,100	0	0	0	951,100	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	51,233	12,715	41,643	6,483	112,074	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	5,370,969	96,750	316,874	504,623	6,289,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,551,442	1,850,802	6,061,741	6,748,356	113,958,556	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,632	0	0	8,632	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,878	30,824	0	0	43,702	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	474,442	13,752	45,041	30,125	563,360	194.01
194.02	07953	SENIOR CIRCLE	71,630	0	0	7,839	79,469	194.02
194.03	07952	MOB	0	106,819	349,854	0	456,673	194.03
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	115,110,392	2,010,829	6,456,636	6,786,320	115,110,392	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	17,534,027					5.00
7.00	00700	OPERATION OF PLANT	1,303,161	8,555,232				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	191,766	366,619	1,625,562			8.00
9.00	00900	HOUSEKEEPING	557,761	0	0	3,661,695		9.00
10.00	01000	DIETARY	493,589	283,507	8,750	126,776	3,659,435	10.00
11.00	01100	CAFETERIA	34,427	259,168	0	115,892	1,529,770	11.00
13.00	01300	NURSING ADMINISTRATION	606,024	28,796	0	12,877	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	224,223	174,021	0	77,817	0	14.00
15.00	01500	PHARMACY	387,318	82,190	0	36,753	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	385,613	92,603	0	41,409	0	16.00
17.00	01700	SOCIAL SERVICE	450	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,862,495	1,523,636	385,401	681,322	1,358,923	30.00
31.00	03100	INTENSIVE CARE UNIT	898,370	311,404	97,386	139,250	90,341	31.00
40.00	04000	SUBPROVIDER - IPF	400,611	189,791	0	84,868	192,631	40.00
43.00	04300	NURSERY	161,284	115,743	10,146	51,757	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,168,130	971,086	268,396	434,240	386	50.00
51.00	05100	RECOVERY ROOM	174,386	111,415	41,856	49,821	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	577,783	184,498	103,077	82,502	1,091	52.00
53.00	05300	ANESTHESIOLOGY	42,804	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	631,074	389,009	144,674	173,953	0	54.00
54.01	05401	ULTRASOUND	124,887	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	126,022	60,250	16,749	26,942	0	56.00
57.00	05700	CT SCAN	184,990	116,750	0	52,207	0	57.00
58.00	05800	MRI	72,498	22,283	0	9,964	0	58.00
60.00	06000	LABORATORY	1,048,265	308,276	0	137,851	0	60.00
65.00	06500	RESPIRATORY THERAPY	246,648	85,211	13,745	38,104	0	65.00
66.00	06600	PHYSICAL THERAPY	196,688	239,370	42,607	107,039	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,862	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	58,480	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	763,243	1,081,044	116,971	483,409	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	445,139	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,055,182	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,687	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	170,908	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	20,139	73,534	6,337	32,882	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,130,141	559,537	316,207	250,208	47,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,327,048	7,629,741	1,572,302	3,247,843	3,220,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,551	49,922	0	22,324	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,853	178,263	12,049	79,714	371,265	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	101,233	79,533	0	35,565	0	194.01
194.02	07953	SENIOR CIRCLE	14,280	0	0	0	67,785	194.02
194.03	07952	MOB	82,062	617,773	41,211	276,249	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,534,027	8,555,232	1,625,562	3,661,695	3,659,435	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	2,130,840					11.00
13.00	01300	NURSING ADMINISTRATION	94,819	4,115,030				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41,317	0	1,765,174			14.00
15.00	01500	PHARMACY	71,400	231,472	0	2,964,550		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	38,042	0	481	0	2,704,080	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	620,132	1,524,220	113,424	0	214,954	30.00
31.00	03100	INTENSIVE CARE UNIT	140,134	433,741	31,479	0	37,438	31.00
40.00	04000	SUBPROVIDER - IPF	82,595	187,422	5,897	0	26,131	40.00
43.00	04300	NURSERY	26,732	66,560	9,840	0	41,787	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	143,523	417,725	152,527	0	472,907	50.00
51.00	05100	RECOVERY ROOM	28,331	96,778	2,035	0	31,708	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	101,521	271,781	32,694	0	37,162	52.00
53.00	05300	ANESTHESIOLOGY	5,141	11,213	16,422	0	58,914	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	88,688	0	14,232	0	85,157	54.00
54.01	05401	ULTRASOUND	22,010	0	2,143	0	42,770	54.01
56.00	05600	RADIOISOTOPE	8,111	0	1,091	0	20,328	56.00
57.00	05700	CT SCAN	28,179	0	10,910	0	178,847	57.00
58.00	05800	MRI	8,035	0	2,160	0	33,208	58.00
60.00	06000	LABORATORY	155,519	0	125,165	0	397,532	60.00
65.00	06500	RESPIRATORY THERAPY	53,388	127,615	16,684	0	60,408	65.00
66.00	06600	PHYSICAL THERAPY	35,262	0	1,716	0	20,297	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,065	0	8	0	2,925	67.00
68.00	06800	SPEECH PATHOLOGY	12,871	0	532	0	7,177	68.00
69.00	06900	ELECTROCARDIOLOGY	112,222	261,645	45,706	0	137,948	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	326,756	0	40,403	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	740,885	0	193,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,964,550	149,726	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,408	0	13,238	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,666	6,150	174	0	1,788	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	194,094	478,708	110,548	0	398,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,119,797	4,115,030	1,764,917	2,964,550	2,704,080	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	198	0	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	7,235	0	59	0	0	194.01
194.02	07953	SENIOR CIRCLE	3,808	0	0	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,130,840	4,115,030	1,765,174	2,964,550	2,704,080	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	2,952					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,104	25,216,136	0	25,216,136		30.00
31.00	03100	INTENSIVE CARE UNIT	222	7,179,181	0	7,179,181		31.00
40.00	04000	SUBPROVIDER - IPF	301	3,399,640	0	3,399,640		40.00
43.00	04300	NURSERY	325	1,381,717	0	1,381,717		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,529,545	0	10,529,545		50.00
51.00	05100	RECOVERY ROOM	0	1,506,787	0	1,506,787		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,607,462	0	4,607,462		52.00
53.00	05300	ANESTHESIOLOGY	0	372,698	0	372,698		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,038,702	0	5,038,702		54.00
54.01	05401	ULTRASOUND	0	886,806	0	886,806		54.01
56.00	05600	RADIOISOTOPE	0	960,801	0	960,801		56.00
57.00	05700	CT SCAN	0	1,601,347	0	1,601,347		57.00
58.00	05800	MRI	0	551,596	0	551,596		58.00
60.00	06000	LABORATORY	0	8,006,187	0	8,006,187		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,014,395	0	2,014,395		65.00
66.00	06600	PHYSICAL THERAPY	0	1,737,547	0	1,737,547		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	164,653	0	164,653		67.00
68.00	06800	SPEECH PATHOLOGY	0	404,498	0	404,498		68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,249,622	0	7,249,622		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,289,488	0	3,289,488		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,861,468	0	7,861,468		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,782,048	0	6,782,048		73.00
74.00	07400	RENAL DIALYSIS	0	1,136,654	0	1,136,654		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	255,744	0	255,744		76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	9,773,902	0	9,773,902		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,952	111,908,624	0	111,908,624		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82,429	0	82,429		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	693,044	0	693,044		192.00
194.00	07950	CHF CLINIC	0	0	0	0		194.00
194.01	07951	MARKETING	0	786,985	0	786,985		194.01
194.02	07953	SENIOR CIRCLE	0	165,342	0	165,342		194.02
194.03	07952	MOB	0	1,473,968	0	1,473,968		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	2,952	115,110,392	0	115,110,392		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,203	39,969	52,172	52,172	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	200,764	657,543	858,307	5,087	5.00
7.00	00700	OPERATION OF PLANT	0	318,575	1,043,397	1,361,972	1,319	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	63,392	207,621	271,013	51	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	603	9.00
10.00	01000	DIETARY	0	49,021	160,554	209,575	0	10.00
11.00	01100	CAFETERIA	0	44,813	146,770	191,583	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	4,979	16,308	21,287	2,815	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,090	98,551	128,641	518	14.00
15.00	01500	PHARMACY	0	14,211	46,545	60,756	1,875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,012	52,442	68,454	546	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	263,452	862,859	1,126,311	12,365	30.00
31.00	03100	INTENSIVE CARE UNIT	0	53,845	176,353	230,198	3,514	31.00
40.00	04000	SUBPROVIDER - IPF	0	32,817	107,481	140,298	1,518	40.00
43.00	04300	NURSERY	0	20,013	65,547	85,560	539	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	167,911	549,940	717,851	3,384	50.00
51.00	05100	RECOVERY ROOM	0	19,265	63,096	82,361	784	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	31,902	104,484	136,386	2,202	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	91	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,263	220,301	287,564	1,911	54.00
54.01	05401	ULTRASOUND	0	0	0	0	563	54.01
56.00	05600	RADIOISOTOPE	0	10,418	34,120	44,538	259	56.00
57.00	05700	CT SCAN	0	20,187	66,117	86,304	681	57.00
58.00	05800	MRI	0	3,853	12,619	16,472	248	58.00
60.00	06000	LABORATORY	0	53,304	174,581	227,885	2,718	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,734	48,256	62,990	1,034	65.00
66.00	06600	PHYSICAL THERAPY	0	41,390	135,559	176,949	798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	115	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	292	68.00
69.00	06900	ELECTROCARDIOLOGY	0	186,923	612,211	799,134	2,120	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	12,715	41,643	54,358	50	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	96,750	316,874	413,624	3,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,850,802	6,061,741	7,912,543	51,880	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,632	0	8,632	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	30,824	0	30,824	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	13,752	45,041	58,793	232	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	0	60	194.02
194.03	07952	MOB	0	106,819	349,854	456,673	0	194.03
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,010,829	6,456,636	8,467,465	52,172	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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	863,394					5.00
7.00	00700	OPERATION OF PLANT	64,166	1,427,457				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,442	61,171	341,677			8.00
9.00	00900	HOUSEKEEPING	27,464	0	0	28,067		9.00
10.00	01000	DIETARY	24,304	47,304	1,839	972	283,994	10.00
11.00	01100	CAFETERIA	1,695	43,243	0	888	118,719	11.00
13.00	01300	NURSING ADMINISTRATION	29,840	4,805	0	99	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,040	29,036	0	596	0	14.00
15.00	01500	PHARMACY	19,071	13,714	0	282	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18,987	15,451	0	317	0	16.00
17.00	01700	SOCIAL SERVICE	22	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	140,983	254,219	81,009	5,224	105,461	30.00
31.00	03100	INTENSIVE CARE UNIT	44,235	51,958	20,469	1,067	7,011	31.00
40.00	04000	SUBPROVIDER - IPF	19,726	31,667	0	651	14,949	40.00
43.00	04300	NURSERY	7,941	19,312	2,133	397	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,518	162,028	56,414	3,328	30	50.00
51.00	05100	RECOVERY ROOM	8,587	18,590	8,798	382	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,449	30,784	21,666	632	85	52.00
53.00	05300	ANESTHESIOLOGY	2,108	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,073	64,907	30,409	1,333	0	54.00
54.01	05401	ULTRASOUND	6,149	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	6,205	10,053	3,520	207	0	56.00
57.00	05700	CT SCAN	9,109	19,480	0	400	0	57.00
58.00	05800	MRI	3,570	3,718	0	76	0	58.00
60.00	06000	LABORATORY	51,616	51,436	0	1,057	0	60.00
65.00	06500	RESPIRATORY THERAPY	12,145	14,218	2,889	292	0	65.00
66.00	06600	PHYSICAL THERAPY	9,685	39,939	8,956	820	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,175	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,879	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37,581	180,374	24,586	3,705	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	21,918	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	51,956	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,509	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,415	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	992	12,269	1,332	252	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	55,647	93,360	66,463	1,918	3,666	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	853,202	1,273,036	330,483	24,895	249,921	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	76	8,330	0	171	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	387	29,744	2,532	611	28,812	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,985	13,270	0	273	0	194.01
194.02	07953	SENIOR CIRCLE	703	0	0	0	5,261	194.02
194.03	07952	MOB	4,041	103,077	8,662	2,117	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	863,394	1,427,457	341,677	28,067	283,994	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	356,128					11.00
13.00	01300	NURSING ADMINISTRATION	15,847	74,693				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,905	0	176,736			14.00
15.00	01500	PHARMACY	11,933	4,201	0	111,832		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,358	0	48	0	110,161	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	103,643	27,668	11,357	0	8,772	30.00
31.00	03100	INTENSIVE CARE UNIT	23,421	7,872	3,152	0	1,528	31.00
40.00	04000	SUBPROVIDER - IPF	13,804	3,402	590	0	1,066	40.00
43.00	04300	NURSERY	4,468	1,208	985	0	1,705	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,987	7,582	15,272	0	19,108	50.00
51.00	05100	RECOVERY ROOM	4,735	1,757	204	0	1,294	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,967	4,933	3,274	0	1,517	52.00
53.00	05300	ANESTHESIOLOGY	859	204	1,644	0	2,404	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,822	0	1,425	0	3,475	54.00
54.01	05401	ULTRASOUND	3,679	0	215	0	1,745	54.01
56.00	05600	RADIOISOTOPE	1,356	0	109	0	830	56.00
57.00	05700	CT SCAN	4,710	0	1,092	0	7,299	57.00
58.00	05800	MRI	1,343	0	216	0	1,355	58.00
60.00	06000	LABORATORY	25,992	0	12,532	0	16,223	60.00
65.00	06500	RESPIRATORY THERAPY	8,923	2,316	1,671	0	2,465	65.00
66.00	06600	PHYSICAL THERAPY	5,893	0	172	0	828	66.00
67.00	06700	OCCUPATIONAL THERAPY	846	0	1	0	119	67.00
68.00	06800	SPEECH PATHOLOGY	2,151	0	53	0	293	68.00
69.00	06900	ELECTROCARDIOLOGY	18,756	4,749	4,576	0	5,630	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	32,717	0	1,649	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	74,178	0	7,890	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	111,832	6,110	73.00
74.00	07400	RENAL DIALYSIS	0	0	141	0	540	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	446	112	17	0	73	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	32,439	8,689	11,069	0	16,243	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	354,283	74,693	176,710	111,832	110,161	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	20	0	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	1,209	0	6	0	0	194.01
194.02	07953	SENIOR CIRCLE	636	0	0	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	356,128	74,693	176,736	111,832	110,161	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	24					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17	1,877,029	0	1,877,029		30.00
31.00	03100	INTENSIVE CARE UNIT	2	394,427	0	394,427		31.00
40.00	04000	SUBPROVIDER - IPF	2	227,673	0	227,673		40.00
43.00	04300	NURSERY	3	124,251	0	124,251		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,066,502	0	1,066,502		50.00
51.00	05100	RECOVERY ROOM	0	127,492	0	127,492		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	246,895	0	246,895		52.00
53.00	05300	ANESTHESIOLOGY	0	7,310	0	7,310		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	436,919	0	436,919		54.00
54.01	05401	ULTRASOUND	0	12,351	0	12,351		54.01
56.00	05600	RADIOISOTOPE	0	67,077	0	67,077		56.00
57.00	05700	CT SCAN	0	129,075	0	129,075		57.00
58.00	05800	MRI	0	26,998	0	26,998		58.00
60.00	06000	LABORATORY	0	389,459	0	389,459		60.00
65.00	06500	RESPIRATORY THERAPY	0	108,943	0	108,943		65.00
66.00	06600	PHYSICAL THERAPY	0	244,040	0	244,040		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,256	0	2,256		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,668	0	5,668		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,081,211	0	1,081,211		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	56,284	0	56,284		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	134,024	0	134,024		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	145,451	0	145,451		73.00
74.00	07400	RENAL DIALYSIS	0	9,096	0	9,096		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	0	69,901	0	69,901		76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	706,996	0	706,996		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24	7,697,328	0	7,697,328		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,209	0	17,209		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	92,930	0	92,930		192.00
194.00	07950	CHF CLINIC	0	0	0	0		194.00
194.01	07951	MARKETING	0	78,768	0	78,768		194.01
194.02	07953	SENIOR CIRCLE	0	6,660	0	6,660		194.02
194.03	07952	MOB	0	574,570	0	574,570		194.03
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	24	8,467,465	0	8,467,465		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	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	542,770					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		532,120				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,294	3,294	47,153,405			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	54,191	54,191	4,599,118	-17,534,027	97,576,365	5.00
7.00	00700	OPERATION OF PLANT	85,991	85,991	1,192,676	0	7,252,071	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,111	17,111	46,268	0	1,067,177	8.00
9.00	00900	HOUSEKEEPING	0	0	545,006	0	3,103,934	9.00
10.00	01000	DIETARY	13,232	13,232	0	0	2,746,813	10.00
11.00	01100	CAFETERIA	12,096	12,096	0	0	191,583	11.00
13.00	01300	NURSING ADMINISTRATION	1,344	1,344	2,545,530	0	3,372,514	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,122	8,122	468,390	0	1,247,796	14.00
15.00	01500	PHARMACY	3,836	3,836	1,695,407	0	2,155,417	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	4,322	493,331	0	2,145,932	16.00
17.00	01700	SOCIAL SERVICE	0	0	2,020	0	2,502	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,112	71,112	11,163,999	0	15,929,525	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	14,534	3,176,912	0	4,999,416	31.00
40.00	04000	SUBPROVIDER - IPF	8,858	8,858	1,372,765	0	2,229,393	40.00
43.00	04300	NURSERY	5,402	5,402	487,513	0	897,543	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	45,323	3,059,605	0	6,500,625	50.00
51.00	05100	RECOVERY ROOM	5,200	5,200	708,846	0	970,457	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	8,611	1,990,645	0	3,215,353	52.00
53.00	05300	ANESTHESIOLOGY	0	0	82,131	0	238,204	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,156	18,156	1,727,879	0	3,511,915	54.00
54.01	05401	ULTRASOUND	0	0	509,356	0	694,996	54.01
56.00	05600	RADIOISOTOPE	2,812	2,812	233,752	0	701,308	56.00
57.00	05700	CT SCAN	5,449	5,449	615,523	0	1,029,464	57.00
58.00	05800	MRI	1,040	1,040	223,817	0	403,448	58.00
60.00	06000	LABORATORY	14,388	14,388	2,457,348	0	5,833,579	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	3,977	934,707	0	1,372,592	65.00
66.00	06600	PHYSICAL THERAPY	11,172	11,172	721,101	0	1,094,568	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	103,901	0	132,793	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	264,349	0	325,438	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	50,455	1,916,405	0	4,247,434	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,477,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,872,074	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,109,085	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	951,100	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,432	3,432	45,043	0	112,074	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	26,115	26,115	3,506,277	0	6,289,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	499,575	499,575	46,889,620	-17,534,027	96,424,529	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	0	0	8,632	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,320	0	0	0	43,702	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,712	3,712	209,316	0	563,360	194.01
194.02	07953	SENIOR CIRCLE	0	0	54,469	0	79,469	194.02
194.03	07952	MOB	28,833	28,833	0	0	456,673	194.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,010,829	6,456,636	6,786,320		17,534,027	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.704753	12.133797	0.143920		0.179695	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			52,172		863,394	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001106		0.008848	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	399,294					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,111	952,512				8.00
9.00	00900	HOUSEKEEPING	0	0	382,183			9.00
10.00	01000	DIETARY	13,232	5,127	13,232	218,049		10.00
11.00	01100	CAFETERIA	12,096	0	12,096	91,152	55,957	11.00
13.00	01300	NURSING ADMINISTRATION	1,344	0	1,344	0	2,490	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,122	0	8,122	0	1,085	14.00
15.00	01500	PHARMACY	3,836	0	3,836	0	1,875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,322	0	4,322	0	999	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,112	225,830	71,112	80,972	16,285	30.00
31.00	03100	INTENSIVE CARE UNIT	14,534	57,064	14,534	5,383	3,680	31.00
40.00	04000	SUBPROVIDER - IPF	8,858	0	8,858	11,478	2,169	40.00
43.00	04300	NURSERY	5,402	5,945	5,402	0	702	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	45,323	157,269	45,323	23	3,769	50.00
51.00	05100	RECOVERY ROOM	5,200	24,526	5,200	0	744	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,611	60,399	8,611	65	2,666	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,156	84,773	18,156	0	2,329	54.00
54.01	05401	ULTRASOUND	0	0	0	0	578	54.01
56.00	05600	RADIOISOTOPE	2,812	9,814	2,812	0	213	56.00
57.00	05700	CT SCAN	5,449	0	5,449	0	740	57.00
58.00	05800	MRI	1,040	0	1,040	0	211	58.00
60.00	06000	LABORATORY	14,388	0	14,388	0	4,084	60.00
65.00	06500	RESPIRATORY THERAPY	3,977	8,054	3,977	0	1,402	65.00
66.00	06600	PHYSICAL THERAPY	11,172	24,966	11,172	0	926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	133	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	338	68.00
69.00	06900	ELECTROCARDIOLOGY	50,455	68,540	50,455	0	2,947	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,432	3,713	3,432	0	70	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	26,115	185,284	26,115	2,815	5,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,099	921,304	338,988	191,888	55,667	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,330	0	2,330	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,320	7,060	8,320	22,122	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,712	0	3,712	0	190	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	4,039	100	194.02
194.03	07952	MOB	28,833	24,148	28,833	0	0	194.03
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)	8,555,232	1,625,562	3,661,695	3,659,435	2,130,840	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.425897	1.706605	9.580999	16.782627	38.079954	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,427,457	341,677	28,067	283,994	356,128	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.574952	0.358711	0.073439	1.302432	6.364315	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 5:05 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING WAGES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	30,140,255					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,990,400				14.00
15.00	01500	PHARMACY	1,695,407	0	3,109,940			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,815	0	782,654,139		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	36,736	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,163,999	898,976	0	62,215,363	26,180	30.00
31.00	03100	INTENSIVE CARE UNIT	3,176,912	249,500	0	10,836,000	2,760	31.00
40.00	04000	SUBPROVIDER - IPF	1,372,765	46,742	0	7,563,336	3,748	40.00
43.00	04300	NURSERY	487,513	77,987	0	12,094,563	4,048	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,059,605	1,208,900	0	136,872,610	0	50.00
51.00	05100	RECOVERY ROOM	708,846	16,129	0	9,177,410	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,990,645	259,123	0	10,756,028	0	52.00
53.00	05300	ANESTHESIOLOGY	82,131	130,156	0	17,051,810	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	112,803	0	24,647,535	0	54.00
54.01	05401	ULTRASOUND	0	16,988	0	12,379,295	0	54.01
56.00	05600	RADIOISOTOPE	0	8,650	0	5,883,786	0	56.00
57.00	05700	CT SCAN	0	86,474	0	51,764,800	0	57.00
58.00	05800	MRI	0	17,117	0	9,611,533	0	58.00
60.00	06000	LABORATORY	0	992,035	0	115,059,770	0	60.00
65.00	06500	RESPIRATORY THERAPY	934,707	132,236	0	17,484,094	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,597	0	5,874,809	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	62	0	846,476	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,218	0	2,077,317	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,916,405	362,254	0	39,927,090	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,589,806	0	11,694,151	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,872,074	0	55,955,759	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	3,109,940	43,336,127	0	73.00
74.00	07400	RENAL DIALYSIS	0	11,161	0	3,831,661	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	45,043	1,382	0	517,456	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,506,277	876,181	0	115,195,360	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,140,255	13,988,366	3,109,940	782,654,139	36,736	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,570	0	0	0	192.00
194.00	07950	CHF CLINIC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	464	0	0	0	194.01
194.02	07953	SENIOR CIRCLE	0	0	0	0	0	194.02
194.03	07952	MOB	0	0	0	0	0	194.03
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)	4,115,030	1,765,174	2,964,550	2,704,080	2,952	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.136529	0.126170	0.953250	0.003455	0.080357	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,693	176,736	111,832	110,161	24	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002478	0.012633	0.035960	0.000141	0.000653	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,216,136		25,216,136	28,158	25,244,294	30.00
31.00	03100	INTENSIVE CARE UNIT	7,179,181		7,179,181	0	7,179,181	31.00
40.00	04000	SUBPROVIDER - IPF	3,399,640		3,399,640	0	3,399,640	40.00
43.00	04300	NURSERY	1,381,717		1,381,717	0	1,381,717	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,529,545		10,529,545	0	10,529,545	50.00
51.00	05100	RECOVERY ROOM	1,506,787		1,506,787	0	1,506,787	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,607,462		4,607,462	0	4,607,462	52.00
53.00	05300	ANESTHESIOLOGY	372,698		372,698	0	372,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,038,702		5,038,702	0	5,038,702	54.00
54.01	05401	ULTRASOUND	886,806		886,806	0	886,806	54.01
56.00	05600	RADIOISOTOPE	960,801		960,801	0	960,801	56.00
57.00	05700	CT SCAN	1,601,347		1,601,347	0	1,601,347	57.00
58.00	05800	MRI	551,596		551,596	0	551,596	58.00
60.00	06000	LABORATORY	8,006,187		8,006,187	0	8,006,187	60.00
65.00	06500	RESPIRATORY THERAPY	2,014,395	0	2,014,395	0	2,014,395	65.00
66.00	06600	PHYSICAL THERAPY	1,737,547	0	1,737,547	0	1,737,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,653	0	164,653	0	164,653	67.00
68.00	06800	SPEECH PATHOLOGY	404,498	0	404,498	0	404,498	68.00
69.00	06900	ELECTROCARDIOLOGY	7,249,622		7,249,622	0	7,249,622	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,289,488		3,289,488	0	3,289,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,861,468		7,861,468	0	7,861,468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,782,048		6,782,048	0	6,782,048	73.00
74.00	07400	RENAL DIALYSIS	1,136,654		1,136,654	0	1,136,654	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	255,744		255,744	0	255,744	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,773,902		9,773,902	0	9,773,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,723,977		2,723,977		2,723,977	92.00
200.00		Subtotal (see instructions)	114,632,601	0	114,632,601	28,158	114,660,759	200.00
201.00		Less Observation Beds	2,723,977		2,723,977		2,723,977	201.00
202.00		Total (see instructions)	111,908,624	0	111,908,624	28,158	111,936,782	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,700,814		52,700,814			30.00
31.00	03100	INTENSIVE CARE UNIT	10,836,000		10,836,000			31.00
40.00	04000	SUBPROVIDER - IPF	7,563,336		7,563,336			40.00
43.00	04300	NURSERY	12,094,563		12,094,563			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,698,720	73,173,890	136,872,610	0.076930	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,975,085	3,202,325	9,177,410	0.164184	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,339,784	416,244	10,756,028	0.428361	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,134,002	8,917,808	17,051,810	0.021857	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,807,292	16,840,243	24,647,535	0.204430	0.000000	54.00
54.01	05401	ULTRASOUND	2,518,194	9,861,101	12,379,295	0.071636	0.000000	54.01
56.00	05600	RADIOISOTOPE	3,020,417	2,863,369	5,883,786	0.163296	0.000000	56.00
57.00	05700	CT SCAN	19,530,646	32,234,154	51,764,800	0.030935	0.000000	57.00
58.00	05800	MRI	5,001,602	4,609,931	9,611,533	0.057389	0.000000	58.00
60.00	06000	LABORATORY	64,594,350	50,465,420	115,059,770	0.069583	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	15,903,106	1,580,988	17,484,094	0.115213	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,796,608	3,078,201	5,874,809	0.295762	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	542,186	304,290	846,476	0.194516	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,712,536	364,781	2,077,317	0.194721	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,065,641	17,861,449	39,927,090	0.181572	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,031,340	4,662,811	11,694,151	0.281293	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,312,813	22,642,946	55,955,759	0.140494	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,238,009	10,098,118	43,336,127	0.156499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,667,985	163,676	3,831,661	0.296648	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	517,456	517,456	0.494233	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	30,307,312	84,888,048	115,195,360	0.084846	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,974,134	6,540,415	9,514,549	0.286296	0.000000	92.00
200.00		Subtotal (see instructions)	427,366,475	355,287,664	782,654,139			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	427,366,475	355,287,664	782,654,139			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.076930		50.00
51.00	05100	RECOVERY ROOM	0.164184		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.428361		52.00
53.00	05300	ANESTHESIOLOGY	0.021857		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.204430		54.00
54.01	05401	ULTRASOUND	0.071636		54.01
56.00	05600	RADIOISOTOPE	0.163296		56.00
57.00	05700	CT SCAN	0.030935		57.00
58.00	05800	MRI	0.057389		58.00
60.00	06000	LABORATORY	0.069583		60.00
65.00	06500	RESPIRATORY THERAPY	0.115213		65.00
66.00	06600	PHYSICAL THERAPY	0.295762		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194516		67.00
68.00	06800	SPEECH PATHOLOGY	0.194721		68.00
69.00	06900	ELECTROCARDIOLOGY	0.181572		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281293		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140494		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156499		73.00
74.00	07400	RENAL DIALYSIS	0.296648		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.494233		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.084846		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.286296		92.00
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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:05 pm

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	25,216,136		25,216,136	28,158	25,244,294	30.00
31.00	03100	INTENSIVE CARE UNIT	7,179,181		7,179,181	0	7,179,181	31.00
40.00	04000	SUBPROVIDER - IPF	3,399,640		3,399,640	0	3,399,640	40.00
43.00	04300	NURSERY	1,381,717		1,381,717	0	1,381,717	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,529,545		10,529,545	0	10,529,545	50.00
51.00	05100	RECOVERY ROOM	1,506,787		1,506,787	0	1,506,787	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,607,462		4,607,462	0	4,607,462	52.00
53.00	05300	ANESTHESIOLOGY	372,698		372,698	0	372,698	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,038,702		5,038,702	0	5,038,702	54.00
54.01	05401	ULTRASOUND	886,806		886,806	0	886,806	54.01
56.00	05600	RADIOISOTOPE	960,801		960,801	0	960,801	56.00
57.00	05700	CT SCAN	1,601,347		1,601,347	0	1,601,347	57.00
58.00	05800	MRI	551,596		551,596	0	551,596	58.00
60.00	06000	LABORATORY	8,006,187		8,006,187	0	8,006,187	60.00
65.00	06500	RESPIRATORY THERAPY	2,014,395	0	2,014,395	0	2,014,395	65.00
66.00	06600	PHYSICAL THERAPY	1,737,547	0	1,737,547	0	1,737,547	66.00
67.00	06700	OCCUPATIONAL THERAPY	164,653	0	164,653	0	164,653	67.00
68.00	06800	SPEECH PATHOLOGY	404,498	0	404,498	0	404,498	68.00
69.00	06900	ELECTROCARDIOLOGY	7,249,622		7,249,622	0	7,249,622	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,289,488		3,289,488	0	3,289,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,861,468		7,861,468	0	7,861,468	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,782,048		6,782,048	0	6,782,048	73.00
74.00	07400	RENAL DIALYSIS	1,136,654		1,136,654	0	1,136,654	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	255,744		255,744	0	255,744	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	9,773,902		9,773,902	0	9,773,902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,723,977		2,723,977		2,723,977	92.00
200.00		Subtotal (see instructions)	114,632,601	0	114,632,601	28,158	114,660,759	200.00
201.00		Less Observation Beds	2,723,977		2,723,977		2,723,977	201.00
202.00		Total (see instructions)	111,908,624	0	111,908,624	28,158	111,936,782	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:05 pm

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	52,700,814		52,700,814			30.00
31.00	03100	INTENSIVE CARE UNIT	10,836,000		10,836,000			31.00
40.00	04000	SUBPROVIDER - IPF	7,563,336		7,563,336			40.00
43.00	04300	NURSERY	12,094,563		12,094,563			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	63,698,720	73,173,890	136,872,610	0.076930	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,975,085	3,202,325	9,177,410	0.164184	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,339,784	416,244	10,756,028	0.428361	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,134,002	8,917,808	17,051,810	0.021857	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,807,292	16,840,243	24,647,535	0.204430	0.000000	54.00
54.01	05401	ULTRASOUND	2,518,194	9,861,101	12,379,295	0.071636	0.000000	54.01
56.00	05600	RADIOISOTOPE	3,020,417	2,863,369	5,883,786	0.163296	0.000000	56.00
57.00	05700	CT SCAN	19,530,646	32,234,154	51,764,800	0.030935	0.000000	57.00
58.00	05800	MRI	5,001,602	4,609,931	9,611,533	0.057389	0.000000	58.00
60.00	06000	LABORATORY	64,594,350	50,465,420	115,059,770	0.069583	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	15,903,106	1,580,988	17,484,094	0.115213	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,796,608	3,078,201	5,874,809	0.295762	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	542,186	304,290	846,476	0.194516	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,712,536	364,781	2,077,317	0.194721	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	22,065,641	17,861,449	39,927,090	0.181572	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,031,340	4,662,811	11,694,151	0.281293	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,312,813	22,642,946	55,955,759	0.140494	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,238,009	10,098,118	43,336,127	0.156499	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,667,985	163,676	3,831,661	0.296648	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	517,456	517,456	0.494233	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	30,307,312	84,888,048	115,195,360	0.084846	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,974,134	6,540,415	9,514,549	0.286296	0.000000	92.00
200.00		Subtotal (see instructions)	427,366,475	355,287,664	782,654,139			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	427,366,475	355,287,664	782,654,139			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 5:05 pm

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
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,877,029	0	1,877,029	28,766	65.25	30.00
31.00	INTENSIVE CARE UNIT	394,427		394,427	2,760	142.91	31.00
40.00	SUBPROVIDER - IPF	227,673	0	227,673	3,748	60.75	40.00
43.00	NURSERY	124,251		124,251	4,048	30.69	43.00
200.00	Total (lines 30 through 199)	2,623,380		2,623,380	39,322		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	8,716	568,719	30.00
31.00	INTENSIVE CARE UNIT	973	139,051	31.00
40.00	SUBPROVIDER - IPF	1,993	121,075	40.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	11,682	828,845	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,066,502	136,872,610	0.007792	19,612,767	152,823	50.00
51.00	05100	RECOVERY ROOM	127,492	9,177,410	0.013892	644,408	8,952	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	246,895	10,756,028	0.022954	57,939	1,330	52.00
53.00	05300	ANESTHESIOLOGY	7,310	17,051,810	0.000429	2,171,433	932	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	436,919	24,647,535	0.017727	3,044,109	53,963	54.00
54.01	05401	ULTRASOUND	12,351	12,379,295	0.000998	671,759	670	54.01
56.00	05600	RADIOISOTOPE	67,077	5,883,786	0.011400	1,223,015	13,942	56.00
57.00	05700	CT SCAN	129,075	51,764,800	0.002493	6,598,485	16,450	57.00
58.00	05800	MRI	26,998	9,611,533	0.002809	1,464,083	4,113	58.00
60.00	06000	LABORATORY	389,459	115,059,770	0.003385	20,087,208	67,995	60.00
65.00	06500	RESPIRATORY THERAPY	108,943	17,484,094	0.006231	5,682,496	35,408	65.00
66.00	06600	PHYSICAL THERAPY	244,040	5,874,809	0.041540	1,090,153	45,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,256	846,476	0.002665	220,249	587	67.00
68.00	06800	SPEECH PATHOLOGY	5,668	2,077,317	0.002729	316,320	863	68.00
69.00	06900	ELECTROCARDIOLOGY	1,081,211	39,927,090	0.027080	7,661,337	207,469	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,284	11,694,151	0.004813	2,439,493	11,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,024	55,955,759	0.002395	13,355,986	31,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,451	43,336,127	0.003356	10,228,882	34,328	73.00
74.00	07400	RENAL DIALYSIS	9,096	3,831,661	0.002374	1,741,220	4,134	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	69,901	517,456	0.135086	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	706,996	115,195,360	0.006137	8,973,543	55,071	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	202,541	9,514,549	0.021288	1,027,706	21,878	92.00
200.00		Total (lines 50 through 199)	5,276,489	699,459,426		108,312,591	769,922	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	28,766	0.00	8,716	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,760	0.00	973	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,748	0.00	1,993	40.00
43.00	04300	NURSERY		0	4,048	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	39,322		11,682	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	136,872,610	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,177,410	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,756,028	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17,051,810	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,647,535	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	12,379,295	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,883,786	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	51,764,800	0.000000	57.00
58.00	05800	MRI	0	0	0	9,611,533	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	115,059,770	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,484,094	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,874,809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	846,476	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,077,317	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	39,927,090	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,694,151	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55,955,759	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,336,127	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,831,661	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	517,456	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	115,195,360	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,514,549	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	699,459,426		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	19,612,767	0	21,618,606	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	644,408	0	752,782	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	57,939	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,171,433	0	2,155,831	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,044,109	0	2,121,318	0	54.00
54.01	05401	ULTRASOUND	0.000000	671,759	0	535,047	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	1,223,015	0	761,927	0	56.00
57.00	05700	CT SCAN	0.000000	6,598,485	0	6,188,080	0	57.00
58.00	05800	MRI	0.000000	1,464,083	0	1,090,764	0	58.00
60.00	06000	LABORATORY	0.000000	20,087,208	0	6,705,225	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	5,682,496	0	315,375	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,090,153	0	33,762	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	220,249	0	3,379	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	316,320	0	18,186	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	7,661,337	0	6,029,849	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,439,493	0	927,166	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	13,355,986	0	10,852,253	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	10,228,882	0	1,896,466	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,741,220	0	102,301	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	57,131	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	8,973,543	0	9,672,531	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,027,706	0	1,612,259	0	92.00
200.00		Total (lines 50 through 199)		108,312,591	0	73,450,238	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.076930	21,618,606	24,917	0	1,663,119	50.00
51.00	05100	RECOVERY ROOM	0.164184	752,782	0	0	123,595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.428361	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021857	2,155,831	0	0	47,120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.204430	2,121,318	0	0	433,661	54.00
54.01	05401	ULTRASOUND	0.071636	535,047	0	0	38,329	54.01
56.00	05600	RADIOISOTOPE	0.163296	761,927	0	0	124,420	56.00
57.00	05700	CT SCAN	0.030935	6,188,080	0	0	191,428	57.00
58.00	05800	MRI	0.057389	1,090,764	0	0	62,598	58.00
60.00	06000	LABORATORY	0.069583	6,705,225	0	0	466,570	60.00
65.00	06500	RESPIRATORY THERAPY	0.115213	315,375	0	0	36,335	65.00
66.00	06600	PHYSICAL THERAPY	0.295762	33,762	0	0	9,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194516	3,379	0	0	657	67.00
68.00	06800	SPEECH PATHOLOGY	0.194721	18,186	0	0	3,541	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181572	6,029,849	0	0	1,094,852	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281293	927,166	0	0	260,805	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140494	10,852,253	0	0	1,524,676	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156499	1,896,466	0	47,294	296,795	73.00
74.00	07400	RENAL DIALYSIS	0.296648	102,301	0	0	30,347	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.494233	57,131	0	0	28,236	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.084846	9,672,531	0	0	820,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.286296	1,612,259	0	0	461,583	92.00
200.00		Subtotal (see instructions)		73,450,238	24,917	47,294	7,719,329	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		73,450,238	24,917	47,294	7,719,329	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,917	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,401		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
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)	1,917	7,401		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,917	7,401		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,066,502	136,872,610	0.007792	2,451	19	50.00
51.00	05100	RECOVERY ROOM	127,492	9,177,410	0.013892	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	246,895	10,756,028	0.022954	0	0	52.00
53.00	05300	ANESTHESIOLOGY	7,310	17,051,810	0.000429	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	436,919	24,647,535	0.017727	27,079	480	54.00
54.01	05401	ULTRASOUND	12,351	12,379,295	0.000998	10,871	11	54.01
56.00	05600	RADIOISOTOPE	67,077	5,883,786	0.011400	5,295	60	56.00
57.00	05700	CT SCAN	129,075	51,764,800	0.002493	47,836	119	57.00
58.00	05800	MRI	26,998	9,611,533	0.002809	4,926	14	58.00
60.00	06000	LABORATORY	389,459	115,059,770	0.003385	478,684	1,620	60.00
65.00	06500	RESPIRATORY THERAPY	108,943	17,484,094	0.006231	132,946	828	65.00
66.00	06600	PHYSICAL THERAPY	244,040	5,874,809	0.041540	85,248	3,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,256	846,476	0.002665	9,799	26	67.00
68.00	06800	SPEECH PATHOLOGY	5,668	2,077,317	0.002729	49,942	136	68.00
69.00	06900	ELECTROCARDIOLOGY	1,081,211	39,927,090	0.027080	34,569	936	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	56,284	11,694,151	0.004813	5,392	26	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	134,024	55,955,759	0.002395	1,210	3	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	145,451	43,336,127	0.003356	568,420	1,908	73.00
74.00	07400	RENAL DIALYSIS	9,096	3,831,661	0.002374	58,346	139	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	69,901	517,456	0.135086	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	706,996	115,195,360	0.006137	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,514,549	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	5,073,948	699,459,426		1,523,014	9,866	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0118
Component CCN: 14-S118
Period: From 01/01/2017 To 12/31/2017
Worksheet D Part IV
Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	136,872,610	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,177,410	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,756,028	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	17,051,810	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	24,647,535	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	12,379,295	0.000000	54.01
56.00	05600	RADIOISOTOPE	0	0	0	5,883,786	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	51,764,800	0.000000	57.00
58.00	05800	MRI	0	0	0	9,611,533	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	115,059,770	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,484,094	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,874,809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	846,476	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,077,317	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	39,927,090	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,694,151	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	55,955,759	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	43,336,127	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,831,661	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0.000000	76.00
76.01	03610	SLEEP LAB	0	0	0	517,456	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	115,195,360	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,514,549	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	699,459,426		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,451	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	27,079	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	10,871	0	2,460	0	54.01
56.00	05600	RADIOISOTOPE	0.000000	5,295	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	47,836	0	2,898	0	57.00
58.00	05800	MRI	0.000000	4,926	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	478,684	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	132,946	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	85,248	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	9,799	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	49,942	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	34,569	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,392	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,210	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	568,420	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	58,346	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.000000	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	0	0	925	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,523,014	0	6,283	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.076930	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.164184	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.428361	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021857	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.204430	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.071636	2,460	0	0	176	54.01
56.00	05600	RADIOISOTOPE	0.163296	0	0	0	0	56.00
57.00	05700	CT SCAN	0.030935	2,898	0	0	90	57.00
58.00	05800	MRI	0.057389	0	0	0	0	58.00
60.00	06000	LABORATORY	0.069583	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.115213	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.295762	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194516	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.194721	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181572	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281293	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140494	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156499	0	0	2,407	0	73.00
74.00	07400	RENAL DIALYSIS	0.296648	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.494233	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.084846	925	0	0	78	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.286296	0	0	0	0	92.00
200.00		Subtotal (see instructions)		6,283	0	2,407	344	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		6,283	0	2,407	344	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	377		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	377		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	377		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	28,766	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,766	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)	25,662	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)	8,716	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)	25,244,294	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)	25,244,294	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)	25,244,294	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)	877.57	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,648,900	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)	7,648,900	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,179,181	2,760	2,601.15	973	2,530,919	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	12,451,134	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	22,630,953	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)	707,770	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	769,922	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,477,692	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	21,153,261	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,104	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	877.57	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,723,977	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,877,029	25,244,294	0.074355	2,723,977	202,541	90.00
91.00	Nursing School cost	0	25,244,294	0.000000	2,723,977	0	91.00
92.00	Allied health cost	0	25,244,294	0.000000	2,723,977	0	92.00
93.00	All other Medical Education	0	25,244,294	0.000000	2,723,977	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0118 Component CCN: 14-S118	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,748	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,748	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,748	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,993	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)	3,399,640	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)	3,399,640	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)	3,399,640	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)	907.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,807,751	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,807,751	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	208,830	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,016,581	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)	121,075	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,866	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	130,941	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,885,640	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	227,673	3,399,640	0.066970	0	0	90.00
91.00	Nursing School cost	0	3,399,640	0.000000	0	0	91.00
92.00	Allied health cost	0	3,399,640	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,399,640	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		18,174,055		30.00
31.00	03100	INTENSIVE CARE UNIT		3,816,245		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076930	19,612,767	1,508,810	50.00
51.00	05100	RECOVERY ROOM	0.164184	644,408	105,801	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.428361	57,939	24,819	52.00
53.00	05300	ANESTHESIOLOGY	0.021857	2,171,433	47,461	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.204430	3,044,109	622,307	54.00
54.01	05401	ULTRASOUND	0.071636	671,759	48,122	54.01
56.00	05600	RADIOISOTOPE	0.163296	1,223,015	199,713	56.00
57.00	05700	CT SCAN	0.030935	6,598,485	204,124	57.00
58.00	05800	MRI	0.057389	1,464,083	84,022	58.00
60.00	06000	LABORATORY	0.069583	20,087,208	1,397,728	60.00
65.00	06500	RESPIRATORY THERAPY	0.115213	5,682,496	654,697	65.00
66.00	06600	PHYSICAL THERAPY	0.295762	1,090,153	322,426	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194516	220,249	42,842	67.00
68.00	06800	SPEECH PATHOLOGY	0.194721	316,320	61,594	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181572	7,661,337	1,391,084	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281293	2,439,493	686,212	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140494	13,355,986	1,876,436	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156499	10,228,882	1,600,810	73.00
74.00	07400	RENAL DIALYSIS	0.296648	1,741,220	516,529	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.494233	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.084846	8,973,543	761,369	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.286296	1,027,706	294,228	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		108,312,591	12,451,134	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)		108,312,591		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		4,018,471		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.076930	2,451	189	50.00
51.00	05100	RECOVERY ROOM	0.164184	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.428361	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.021857	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.204430	27,079	5,536	54.00
54.01	05401	ULTRASOUND	0.071636	10,871	779	54.01
56.00	05600	RADIOISOTOPE	0.163296	5,295	865	56.00
57.00	05700	CT SCAN	0.030935	47,836	1,480	57.00
58.00	05800	MRI	0.057389	4,926	283	58.00
60.00	06000	LABORATORY	0.069583	478,684	33,308	60.00
65.00	06500	RESPIRATORY THERAPY	0.115213	132,946	15,317	65.00
66.00	06600	PHYSICAL THERAPY	0.295762	85,248	25,213	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.194516	9,799	1,906	67.00
68.00	06800	SPEECH PATHOLOGY	0.194721	49,942	9,725	68.00
69.00	06900	ELECTROCARDIOLOGY	0.181572	34,569	6,277	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.281293	5,392	1,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.140494	1,210	170	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.156499	568,420	88,957	73.00
74.00	07400	RENAL DIALYSIS	0.296648	58,346	17,308	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.494233	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.084846	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.286296	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,523,014	208,830	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,523,014		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	13,251,245	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,621,607	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)	228,391	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)	289.50	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	8.02	30.00
31.00	Percentage of Medicaid patient days (see instructions)	38.04	31.00
32.00	Sum of lines 30 and 31	46.06	32.00
33.00	Allowable disproportionate share percentage (see instructions)	27.21	33.00
34.00	Disproportionate share adjustment (see instructions)	1,215,801	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	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)	2,252,970	1,941,753	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,685,098	489,429	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,174,527		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	21,491,571		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)	21,491,571	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,592,186	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	3,107	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)	23,086,864	59.00
60.00	Primary payer payments	16,220	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	23,070,644	61.00
62.00	Deductibles billed to program beneficiaries	1,814,120	62.00
63.00	Coinsurance billed to program beneficiaries	94,066	63.00
64.00	Allowable bad debts (see instructions)	645,787	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	419,762	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	535,165	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	21,582,220	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	-38,053	70.93
70.94	HRR adjustment amount (see instructions)	-341,265	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,202,902	71.00
71.01	Sequestration adjustment (see instructions)		424,058	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		19,928,675	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		850,169	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		3,227,461	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	9,318	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	7,719,329	2.00
3.00	OPPS payments	7,707,406	3.00
4.00	Outlier payment (see instructions)	32,781	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	9,318	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	72,211	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)	72,211	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)	72,211	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	62,893	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	9,318	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	7,740,187	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	4,983	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,328,953	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)	6,415,569	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)	6,415,569	30.00
31.00	Primary payer payments	5,248	31.00
32.00	Subtotal (line 30 minus line 31)	6,410,321	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)	283,388	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	184,202	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	240,951	36.00
37.00	Subtotal (see instructions)	6,594,523	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-188	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,594,711	40.00
40.01	Sequestration adjustment (see instructions)	131,894	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,503,794	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-40,977	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118 Component CCN: 14-S118	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	377	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	344	2.00
3.00	OPPS payments	701	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	377	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	2,407	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	2,407	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	2,407	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,030	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	377	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	701	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)	69	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,009	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,009	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	1,009	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,009	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,009	40.00
40.01	Sequestration adjustment (see instructions)	20	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	977	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	12	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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		19,924,833		6,551,154	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	08/24/2017	3,842		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	08/24/2017	47,360	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)		3,842		-47,360	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)		19,928,675		6,503,794	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		850,169		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		40,977	6.02
7.00	Total Medicare program liability (see instructions)		20,778,844		6,462,817	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0118 | Component CCN: 14-S118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2018 5:05 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,865,026		977	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,865,026		977	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		17,700		12	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,882,726		989	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: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0118 Component CCN: 14-S118	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,999,552	1.00
2.00	Net IPF PPS Outlier Payments	46,574	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.268493	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,046,126	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,046,126	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,046,126	18.00
19.00	Deductibles	123,620	19.00
20.00	Subtotal (line 18 minus line 19)	1,922,506	20.00
21.00	Coinsurance	19,411	21.00
22.00	Subtotal (line 20 minus line 21)	1,903,095	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,775	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	18,054	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,945	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,921,149	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,921,149	31.00
31.01	Sequestration adjustment (see instructions)	38,423	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	1,865,026	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	17,700	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	46,574	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/24/2018 5:05 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,769,589	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	48,787,245	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,669,009	0	0	0	6.00
7.00	Inventory	3,942,139	0	0	0	7.00
8.00	Prepaid expenses	888,427	0	0	0	8.00
9.00	Other current assets	339,295	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)	44,518,508	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,610,000	0	0	0	12.00
13.00	Land improvements	2,439,950	0	0	0	13.00
14.00	Accumulated depreciation	-2,338,124	0	0	0	14.00
15.00	Buildings	23,386,927	0	0	0	15.00
16.00	Accumulated depreciation	-6,085,152	0	0	0	16.00
17.00	Leasehold improvements	5,803,690	0	0	0	17.00
18.00	Accumulated depreciation	-1,574,075	0	0	0	18.00
19.00	Fixed equipment	1,915,535	0	0	0	19.00
20.00	Accumulated depreciation	-1,011,270	0	0	0	20.00
21.00	Automobiles and trucks	21,120	0	0	0	21.00
22.00	Accumulated depreciation	-21,120	0	0	0	22.00
23.00	Major movable equipment	14,516,617	0	0	0	23.00
24.00	Accumulated depreciation	-10,987,108	0	0	0	24.00
25.00	Minor equipment depreciable	9,160,878	0	0	0	25.00
26.00	Accumulated depreciation	-6,533,055	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)	31,304,813	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	6,978,250	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6,978,250	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	82,801,571	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,945,178	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,854,743	0	0	0	38.00
39.00	Payroll taxes payable	489,596	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	5,973,737	0	0	0	43.00
44.00	Other current liabilities	1,613,832	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,877,086	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	2,746	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,746	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	22,879,832	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	59,921,739				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)	59,921,739	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	82,801,571	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/24/2018 5:05 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		65,766,443		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-5,220,664				2.00
3.00	Total (sum of line 1 and line 2)		60,545,779		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)		60,545,779		0		11.00
12.00	ADJUSTMENTS	624,040		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)		624,040		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		59,921,739		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	ADJUSTMENTS		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: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/24/2018 5:05 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	64,795,377		64,795,377	1.00
2.00	SUBPROVIDER - IPF	7,563,336		7,563,336	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)	72,358,713		72,358,713	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	10,836,000		10,836,000	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	10,836,000		10,836,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	83,194,713		83,194,713	17.00
18.00	Ancillary services	310,890,316	263,859,201	574,749,517	18.00
19.00	Outpatient services	33,281,446	91,428,463	124,709,909	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)	427,366,475	355,287,664	782,654,139	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		135,014,179		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	ROUNDING	6			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)		6		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		135,014,173		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0118 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/24/2018 5:05 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	782,654,139	1.00
2.00	Less contractual allowances and discounts on patients' accounts	653,338,110	2.00
3.00	Net patient revenues (line 1 minus line 2)	129,316,029	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	135,014,173	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,698,144	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 OPERATING INCOME	477,480	24.00
25.00	Total other income (sum of lines 6-24)	477,480	25.00
26.00	Total (line 5 plus line 25)	-5,220,664	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)	-5,220,664	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0118	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/24/2018 5:05 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,448,957	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	1,521	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)	79.29	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)	8.02	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	38.04	8.00
9.00	Sum of lines 7 and 8	46.06	9.00
10.00	Allowable disproportionate share percentage (see instructions)	9.78	10.00
11.00	Disproportionate share adjustment (see instructions)	141,708	11.00
12.00	Total prospective capital payments (see instructions)	1,592,186	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