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: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/24/2018 12:55 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2018 Time: 12:55 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 ADVOCATE BROMENN MEDICAL CENTER (14-0127) 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	143,385	-2,857	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-21,355	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	122,030	-2,857	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 12:53 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1304 VIRGINIA	PO Box:			1.00
2.00	City: NORMAL	State: IL	Zip Code: 61761-	County: MCLEAN	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	ADVOCATE BROMENN MEDICAL CENTER	140127	14060	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	ADVOCATE BROMENN REHABILITATION	14T127	14060	5	07/01/1990	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,859	2,045	0	0	3,516	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	84	0	0	67		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 12:53 pm

		Urban/Rural St	Date of Geogra	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

		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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 12:53 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)	Y	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)	0.16	6.98	0.022409	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 12:53 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)	FAMILY PRACTICE - OSTEOPATHIC	3630	1.50	6.64	0.184275	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)	0.50	9.85	0.048309	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)	NEURO SURGERY - NEUROLOGY	4300	0.06	9.29	0.006417	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 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)			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.	Y			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)	N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/24/2018 12:53 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.	Y	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 12:53 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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	137,040	210,644	-78,156	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	14H036	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2018 12:53 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ADVOCATE HEALTHCARE	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 3075 HIGHLAND PKWY	PO Box: SUITE 600		142.00
143.00	City: DOWNERS GROVE	State: IL	Zip Code: 60515	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.			145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	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)	Y	3,063	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2018 12:53 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	03/06/2015	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.	Y		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.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/24/2018	Y	04/24/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 12:53 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		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PAMELA	DYE	41.00
42.00	Enter the employer/company name of the cost report preparer	ADVOCATE HEALTHCARE		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-929-5760	PAMELA.DYE@ADVOCATEHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/24/2018 12:53 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.	SENIOR REIMBURSEMENT SPECIALIST		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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 12:53 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	176	64,240	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)		176	64,240	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	30	10,950	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)		206	75,190	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF	41.00	15	5,475		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		221				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 12:53 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,593	1,927	19,823			1.00
2.00	HMO and other (see instructions)	3,063	3,516				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	67				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)	7,593	1,927	19,823			7.00
8.00	INTENSIVE CARE UNIT	2,816	524	7,352			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		1,289	4,457			13.00
14.00	Total (see instructions)	10,409	3,740	31,632	12.57	899.08	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	1,585	84	2,723	0.00	15.62	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	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	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	268			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
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)				12.57	914.70	27.00
28.00	Observation Bed Days		186	3,086			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			527			30.00
31.00	Employee discount days - IRF			22			31.00
32.00	Labor & delivery days (see instructions)	0	163	389			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			30			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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2018 12:53 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	2,502	713	7,902	1.00
2.00	HMO and other (see instructions)			845	1,037		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				7		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	2,502	713	7,902	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0	130	6	219	17.00
18.00	SUBPROVIDER	0.00	0		0	0	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2018 12:53 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	57,646,387	0	57,646,387	1,908,192.00	30.21	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		82,800	0	82,800	552.00	150.00	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		280,059	0	280,059	54.00	5,186.28	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	1,551,889	0	1,551,889	53,456.00	29.03	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		2,185,521	-119,905	2,065,616	91,742.00	22.52	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,887,309	0	1,887,309	46,293.96	40.77	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		2,464,973	0	2,464,973	27,892.00	88.38	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,006,395	0	6,006,395	88,302.00	68.02	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)		14,163,163	0	14,163,163			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		554,163	0	554,163			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		16,074	0	16,074			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		73,927	0	73,927			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		409,654	0	409,654			25.00
25.50	Home office wage-related (core)		1,050,894	0	1,050,894			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	1,732,070	-1,535,441	196,629	7,259.00	27.09	26.00
27.00	Administrative & General	5.00	6,909,453	1,210,412	8,119,865	216,709.00	37.47	27.00
28.00	Administrative & General under contract (see inst.)		404,552	0	404,552	2,174.00	186.09	28.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/24/2018 12:53 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	
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,015,892	-12,917	1,002,975	33,049.00	30.35	30.00
31.00	Laundry & Linen Service	8.00	334,207	-15,674	318,533	23,652.00	13.47	31.00
32.00	Housekeeping	9.00	1,254,651	13,336	1,267,987	89,482.00	14.17	32.00
33.00	Housekeeping under contract (see instructions)		1,350	0	1,350	18.00	75.00	33.00
34.00	Dietary	10.00	1,009,493	-489,180	520,313	32,669.00	15.93	34.00
35.00	Dietary under contract (see instructions)		1,026	0	1,026	12.25	83.76	35.00
36.00	Cafeteria	11.00	0	499,365	499,365	31,354.00	15.93	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,900,629	13,371	1,914,000	51,875.00	36.90	38.00
39.00	Central Services and Supply	14.00	330,930	2,838	333,768	19,053.00	17.52	39.00
40.00	Pharmacy	15.00	2,232,577	31,601	2,264,178	48,687.00	46.50	40.00
41.00	Medical Records & Medical Records Library	16.00	1,197,417	8,321	1,205,738	46,405.00	25.98	41.00
42.00	Social Service	17.00	1,242,476	14,374	1,256,850	32,843.00	38.27	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/24/2018 12:53 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)		56,221,367	0	56,221,367	1,856,886.25	30.28	1.00
2.00	Excluded area salaries (see instructions)		2,185,521	-119,905	2,065,616	91,742.00	22.52	2.00
3.00	Subtotal salaries (line 1 minus line 2)		54,035,846	119,905	54,155,751	1,765,144.25	30.68	3.00
4.00	Subtotal other wages & related costs (see inst.)		10,358,677	0	10,358,677	162,487.96	63.75	4.00
5.00	Subtotal wage-related costs (see inst.)		15,230,131	0	15,230,131	0.00	28.12	5.00
6.00	Total (sum of lines 3 thru 5)		79,624,654	119,905	79,744,559	1,927,632.21	41.37	6.00
7.00	Total overhead cost (see instructions)		19,566,723	-259,594	19,307,129	635,241.25	30.39	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2018 12:53 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,277,054	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)	1,674,603	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	70,329	6.00
7.00	Employee Managed Care Program Administration Fees	771,211	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,415,187	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	1,743,041	9.00
10.00	Dental, Hearing and Vision Plan	245,592	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	76,657	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	359,394	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	736,352	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	4,025,988	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	226,767	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	259,287	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	335,520	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	15,216,982	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/24/2018 12:53 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	1,887,309	15,216,982	1.00
2.00	Hospital	1,887,309	14,163,163	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	247,817	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis			17.00
18.00	Other	0	806,002	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/24/2018 12:53 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)	0.282196	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	15,882,528	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	75,000,343	6.00
7.00	Medicaid cost (line 1 times line 6)	21,164,797	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)	5,282,269	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	5,282,269	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)	5,088,259	788,325	5,876,584	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,435,886	788,325	2,224,211	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,435,886	788,325	2,224,211	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)	1,846,854	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	537,460	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	826,861	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,019,993	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	577,239	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,801,450	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	8,083,719	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 12:53 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	NEW CAP REL COSTS-BLDG & FIXT		5,738,865	5,738,865	0	5,738,865	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	4,716,959	4,716,959	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,732,070	10,900,073	12,632,143	-1,677,395	10,954,748	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,909,453	30,649,842	37,559,295	753,017	38,312,312	5.00
7.00	00700	OPERATION OF PLANT	1,015,892	4,844,804	5,860,696	-206,377	5,654,319	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	334,207	350,663	684,870	-71,288	613,582	8.00
9.00	00900	HOUSEKEEPING	1,254,651	790,212	2,044,863	-14,464	2,030,399	9.00
10.00	01000	DIETARY	1,009,493	996,692	2,006,185	-989,895	1,016,290	10.00
11.00	01100	CAFETERIA	0	0	0	975,373	975,373	11.00
13.00	01300	NURSING ADMINISTRATION	1,900,629	227,780	2,128,409	-3,498	2,124,911	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	330,930	877,662	1,208,592	-522,951	685,641	14.00
15.00	01500	PHARMACY	2,232,577	6,564,664	8,797,241	-221,735	8,575,506	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,197,417	465,880	1,663,297	4,940	1,668,237	16.00
17.00	01700	SOCIAL SERVICE	1,242,476	316,419	1,558,895	14,374	1,573,269	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,551,889	0	1,551,889	0	1,551,889	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	470,738	470,738	6,676	477,414	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	344,360	72,510	416,870	-154,631	262,239	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,515,869	6,637,262	19,153,131	-4,479,283	14,673,848	30.00
31.00	03100	INTENSIVE CARE UNIT	3,693,831	1,582,581	5,276,412	-1,176,829	4,099,583	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	948,347	151,891	1,100,238	2,887	1,103,125	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	2,019,637	2,019,637	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,418,439	16,335,197	19,753,636	-11,810,224	7,943,412	50.00
51.00	05100	RECOVERY ROOM	583,807	81,062	664,869	-31,975	632,894	51.00
53.00	05300	ANESTHESIOLOGY	30,465	1,426,915	1,457,380	-293,178	1,164,202	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,189,164	1,758,797	3,947,961	-1,336,643	2,611,318	54.00
57.00	05700	CT SCAN	415,811	784,737	1,200,548	-596,082	604,466	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,000,853	3,294,799	5,295,652	-2,076,252	3,219,400	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,634,225	1,634,225	64.00
65.00	06500	RESPIRATORY THERAPY	860,548	265,891	1,126,439	-173,215	953,224	65.00
66.00	06600	PHYSICAL THERAPY	1,441,020	321,708	1,762,728	-24,644	1,738,084	66.00
67.00	06700	OCCUPATIONAL THERAPY	406,421	33,763	440,184	-1,184	439,000	67.00
68.00	06800	SPEECH PATHOLOGY	238,138	21,038	259,176	360	259,536	68.00
69.00	06900	ELECTROCARDIOLOGY	1,823,870	3,653,476	5,477,346	-3,282,103	2,195,243	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	87,327	74,561	161,888	-9,725	152,163	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,805,728	10,805,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	9,511,295	9,511,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	357,200	48,415	405,615	-14,126	391,489	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	514,822	77,431	592,253	-2,017	590,236	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	470,281	55,070	525,351	-525,351	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	495,851	833,733	1,329,584	-328,537	1,001,047	90.04
91.00	09100	EMERGENCY	3,205,465	4,006,918	7,212,383	-422,313	6,790,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE		2,709,657	2,709,657	0	2,709,657	113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,753,573	107,421,706	164,175,279	-444	164,174,835	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	418,760	522,286	941,046	-3,979	937,067	190.00
190.01	19001	OTHER NONREIMBURSABLE	474,054	1,380,486	1,854,540	4,423	1,858,963	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	57,646,387	109,324,478	166,970,865	0	166,970,865	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	152,443	5,891,308		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	868,746	5,585,705		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-113,649	10,841,099		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,352,805	19,959,507		5.00
7.00	00700	OPERATION OF PLANT	-3,934	5,650,385		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-219,161	394,421		8.00
9.00	00900	HOUSEKEEPING	-38,820	1,991,579		9.00
10.00	01000	DIETARY	-3,828	1,012,462		10.00
11.00	01100	CAFETERIA	-219,612	755,761		11.00
13.00	01300	NURSING ADMINISTRATION	-18,951	2,105,960		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-6	685,635		14.00
15.00	01500	PHARMACY	-125,424	8,450,082		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,203	1,667,034		16.00
17.00	01700	SOCIAL SERVICE	0	1,573,269		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,551,889		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	26,565	503,979		22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	-9,710	252,529		23.00
23.01	02301	EMS PROGRAM	0	0		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,796,553	11,877,295		30.00
31.00	03100	INTENSIVE CARE UNIT	-157,387	3,942,196		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	-124	1,103,001		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	-4,393	2,015,244		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,029,043	5,914,369		50.00
51.00	05100	RECOVERY ROOM	0	632,894		51.00
53.00	05300	ANESTHESIOLOGY	-1,086,048	78,154		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-23,437	2,587,881		54.00
57.00	05700	CT SCAN	8,311	612,777		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-300,756	2,918,644		60.00
64.00	06400	INTRAVENOUS THERAPY	0	1,634,225		64.00
65.00	06500	RESPIRATORY THERAPY	0	953,224		65.00
66.00	06600	PHYSICAL THERAPY	-57,209	1,680,875		66.00
67.00	06700	OCCUPATIONAL THERAPY	15,241	454,241		67.00
68.00	06800	SPEECH PATHOLOGY	11,659	271,195		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,195,243		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	152,163		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10,805,728		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	9,511,295		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	-291	391,198		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	51,939	642,175		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0		90.03
90.04	09003	WOUND CARE CLINIC	39,841	1,040,888		90.04
91.00	09100	EMERGENCY	-2,772,506	4,017,564		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
113.00	11300	INTEREST EXPENSE	-2,709,657	0		113.00
116.00	11600	HOSPICE	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-29,869,762	134,305,073		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	937,067		190.00
190.01	19001	OTHER NONREIMBURSABLE	140,631	1,999,594		190.01
190.13	19007	EUREKA	0	0		190.13
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-29,729,131	137,241,734		200.00

RECLASSIFICATIONS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 12:53 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - NURSERY EXPENSE				
1.00	NURSERY	43.00	1,769,525	487,269	1.00
	TOTALS		1,769,525	487,269	
	B - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	494,377	476,008	1.00
	TOTALS		494,377	476,008	
	C - MEDICAL SUPPLY RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	20,317,023	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
	TOTALS		0	20,317,023	
	D - MANAGEMENT COMPENSATION RECLASS				
1.00		0.00	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	908,950	0	2.00
3.00	OPERATION OF PLANT	7.00	18,892	0	3.00
4.00	PHARMACY	15.00	32,463	0	4.00
5.00	SOCIAL SERVICE	17.00	9,126	0	5.00
6.00	CLINICAL PASTORAL EDUCATION	23.00	9,704	0	6.00
7.00	ADULTS & PEDIATRICS	30.00	63,887	0	7.00
8.00	NURSERY	43.00	44,911	0	8.00
9.00	OPERATING ROOM	50.00	38,155	0	9.00
10.00	ANESTHESIOLOGY	53.00	2,260	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	16,485	0	11.00
12.00	LABORATORY	60.00	9,704	0	12.00
13.00	RESPIRATORY THERAPY	65.00	8,254	0	13.00
14.00	PHYSICAL THERAPY	66.00	12,037	0	14.00
15.00	ELECTROCARDIOLOGY	69.00	27,666	0	15.00
16.00	EMERGENCY	91.00	11,204	0	16.00
17.00	OTHER NONREIMBURSABLE	190.01	7,271	0	17.00
18.00	CLINIC	90.00	670	0	18.00
19.00	INTRAVENOUS THERAPY	64.00	8,270	0	19.00
	TOTALS		1,229,909	0	
	E - IMPLANT RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	9,511,295	1.00
	TOTALS		0	9,511,295	
	F - EQUIP DEPR EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	4,752,956	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00

RECLASSIFICATIONS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 12:53 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	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
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
	TOTALS		0	4,752,956		
	G - BASIC DIAGNOSTIC TESTING					
1.00	OPERATING ROOM	50.00	442,064	49,394		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	4,703	525		2.00
3.00	LABORATORY	60.00	14,108	1,576		3.00
4.00	ELECTROCARDIOLOGY	69.00	9,406	1,051		4.00
	TOTALS		470,281	52,546		
	H - RECLASS EUREKA ALLOCATED COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	110,857	191,839		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		110,857	191,839		
	I - A&G RELATED CPE COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	149,744	16,873		1.00
	TOTALS		149,744	16,873		
	J - RECLASS MD CONTRACT EXPENSES					
1.00	ADULTS & PEDIATRICS	30.00	0	27,083		1.00
2.00	SUBPROVIDER - IRF	41.00	0	57,275		2.00
3.00	OPERATING ROOM	50.00	0	65,350		3.00
4.00	ELECTROCARDIOLOGY	69.00	0	14,213		4.00
5.00	WOUND CARE CLINIC	90.04	0	11,000		5.00
	TOTALS		0	174,921		
	K - ASSOCIATE BONUS					
1.00	ADMINISTRATIVE & GENERAL	5.00	40,861	0		1.00
2.00	OPERATION OF PLANT	7.00	5,598	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	3,616	0		3.00
4.00	HOUSEKEEPING	9.00	13,336	0		4.00
5.00	DIETARY	10.00	5,197	0		5.00
6.00	CAFETERIA	11.00	4,988	0		6.00
7.00	NURSING ADMINISTRATION	13.00	13,371	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	2,838	0		8.00
9.00	PHARMACY	15.00	10,224	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	8,321	0		10.00
11.00	SOCIAL SERVICE	17.00	5,248	0		11.00
12.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	7,660	0		12.00
13.00	CLINICAL PASTORAL EDUCATION	23.00	2,292	0		13.00
14.00	ADULTS & PEDIATRICS	30.00	46,063	0		14.00
15.00	INTENSIVE CARE UNIT	31.00	14,891	0		15.00
16.00	SUBPROVIDER - IRF	41.00	3,926	0		16.00
17.00	NURSERY	43.00	9,527	0		17.00
18.00	OPERATING ROOM	50.00	18,659	0		18.00
19.00	RECOVERY ROOM	51.00	2,682	0		19.00

RECLASSIFICATIONS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 12:53 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
20.00	ANESTHESIOLOGY	53.00	272	0	20.00
21.00	RADIOLOGY-DIAGNOSTIC	54.00	11,778	0	21.00
22.00	CT SCAN	57.00	2,138	0	22.00
23.00	LABORATORY	60.00	13,796	0	23.00
24.00	RESPIRATORY THERAPY	65.00	5,480	0	24.00
25.00	PHYSICAL THERAPY	66.00	5,792	0	25.00
26.00	OCCUPATIONAL THERAPY	67.00	1,749	0	26.00
27.00	SPEECH PATHOLOGY	68.00	1,244	0	27.00
28.00	ELECTROCARDIOLOGY	69.00	6,725	0	28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	505	0	29.00
30.00	CARDIAC REHABILITATION	76.97	2,060	0	30.00
31.00	CLINIC	90.00	2,643	0	31.00
32.00	WOUND CARE CLINIC	90.04	2,487	0	32.00
33.00	EMERGENCY	91.00	16,753	0	33.00
34.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	4,780	0	34.00
35.00	OTHER NONREIMBURSABLE	190.01	1,866	0	35.00
36.00	INTRAVENOUS THERAPY	64.00	6,166	0	36.00
	TOTALS		305,532	0	
	L - INFUSION THERAPY				
1.00	INTRAVENOUS THERAPY	64.00	1,285,165	334,624	1.00
2.00		0.00	0	0	2.00
	TOTALS		1,285,165	334,624	
500.00	Grand Total: Increases		5,815,390	36,315,354	500.00

RECLASSIFICATIONS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 12:53 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - NURSERY EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	1,769,525	487,269	0		1.00
	TOTALS		1,769,525	487,269			
	B - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	494,377	476,008	0		1.00
	TOTALS		494,377	476,008			
	C - MEDICAL SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,532	0		1.00
2.00	OPERATION OF PLANT	7.00	0	122,115	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	5,021	0		3.00
4.00	HOUSEKEEPING	9.00	0	7,570	0		4.00
5.00	DIETARY	10.00	0	3,843	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	11,356	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	479,792	0		7.00
8.00	PHARMACY	15.00	0	79,139	0		8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	77	0		9.00
10.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	720	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	731,412	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	0	353,725	0		12.00
13.00	SUBPROVIDER - IRF	41.00	0	45,529	0		13.00
14.00	NURSERY	43.00	0	157,779	0		14.00
15.00	OPERATING ROOM	50.00	0	11,790,307	0		15.00
16.00	RECOVERY ROOM	51.00	0	17,037	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	245,963	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	365,750	0		18.00
19.00	CT SCAN	57.00	0	287,835	0		19.00
20.00	LABORATORY	60.00	0	1,980,311	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	114,120	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	18,524	0		22.00
23.00	OCCUPATIONAL THERAPY	67.00	0	2,933	0		23.00
24.00	SPEECH PATHOLOGY	68.00	0	884	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	2,810,098	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,846	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	7,152	0		27.00
28.00	CLINIC	90.00	0	3,899	0		28.00
29.00	WOUND CARE CLINIC	90.04	0	341,210	0		29.00
30.00	EMERGENCY	91.00	0	310,329	0		30.00
31.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2,123	0		31.00
32.00	BASIC DIAGNOSTIC TESTING	90.01	0	2,524	0		32.00
33.00	OTHER NONREIMBURSABLE	190.01	0	2,570	0		33.00
34.00	ADMINISTRATIVE & GENERAL	5.00	0	9,988	0		34.00
35.00	CLINICAL PASTORAL EDUCATION	23.00	0	10	0		35.00
	TOTALS		0	20,317,023			
	D - MANAGEMENT COMPENSATION RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	1,229,909	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
	TOTALS		1,229,909	0			
	E - IMPLANT RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,511,295	0		1.00
	TOTALS		0	9,511,295			
	F - EQUIP DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,604	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	481,198	0		2.00
3.00	OPERATION OF PLANT	7.00	0	71,345	0		3.00

RECLASSIFICATIONS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 12:53 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
4.00	LAUNDRY & LINEN SERVICE	8.00	0	30,569	0		4.00
5.00	HOUSEKEEPING	9.00	0	20,230	0		5.00
6.00	DIETARY	10.00	0	20,864	0		6.00
7.00	NURSING ADMINISTRATION	13.00	0	5,513	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	45,997	0		8.00
9.00	PHARMACY	15.00	0	174,197	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,304	0		10.00
12.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	264	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	540,611	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	305,705	0		14.00
15.00	SUBPROVIDER - IRF	41.00	0	12,785	0		15.00
16.00	NURSERY	43.00	0	133,816	0		16.00
17.00	OPERATING ROOM	50.00	0	633,539	0		17.00
18.00	RECOVERY ROOM	51.00	0	17,620	0		18.00
19.00	ANESTHESIOLOGY	53.00	0	49,747	0		19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	978,646	0		20.00
21.00	CT SCAN	57.00	0	310,385	0		21.00
22.00	LABORATORY	60.00	0	117,789	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	72,829	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	23,949	0		24.00
26.00	ELECTROCARDIOLOGY	69.00	0	531,066	0		26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,384	0		27.00
28.00	CARDIAC REHABILITATION	76.97	0	9,034	0		28.00
29.00	CLINIC	90.00	0	1,431	0		29.00
30.00	WOUND CARE CLINIC	90.04	0	814	0		30.00
31.00	EMERGENCY	91.00	0	139,941	0		31.00
32.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	6,636	0		32.00
33.00	OTHER NONREIMBURSABLE	190.01	0	2,144	0		33.00
	TOTALS		0	4,752,956			
	G - BASIC DIAGNOSTIC TESTING						
1.00	BASIC DIAGNOSTIC TESTING	90.01	470,281	52,546	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		470,281	52,546			
	H - RECLASS EUREKA ALLOCATED COSTS						
1.00		0.00	0	0	0		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	35,997	9		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	135,818	0		3.00
4.00	OPERATION OF PLANT	7.00	37,407	0	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	19,290	20,024	0		5.00
6.00	PHARMACY	15.00	11,086	0	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	25,738	0	0		7.00
8.00	LABORATORY	60.00	17,336	0	0		8.00
	TOTALS		110,857	191,839			
	I - A&G RELATED CPE COSTS						
1.00	CLINICAL PASTORAL EDUCATION	23.00	149,744	16,873	0		1.00
	TOTALS		149,744	16,873			
	J - RECLASS MD CONTRACT EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	174,921	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		0	174,921			
	K - ASSOCIATE BONUS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	305,532	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00

RECLASSIFICATIONS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/24/2018 12:53 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00
29.00		0.00	0	0	0		29.00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0	0		31.00
32.00		0.00	0	0	0		32.00
33.00		0.00	0	0	0		33.00
34.00		0.00	0	0	0		34.00
35.00		0.00	0	0	0		35.00
36.00		0.00	0	0	0		36.00
	TOTALS		305,532	0			
	L - INFUSION THERAPY						
1.00	ADULTS & PEDIATRICS	30.00	859,305	228,194	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	425,860	106,430	0		2.00
	TOTALS		1,285,165	334,624			
500.00	Grand Total: Decreases		5,815,390	36,315,354			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2018 12:53 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	7,844,000	0	0	0	0	1.00
2.00	Land Improvements	9,847,673	348,247	0	348,247	0	2.00
3.00	Buildings and Fixtures	238,206,066	2,465,937	0	2,465,937	37,677	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	84,258,632	6,798,344	0	6,798,344	3,147,551	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	340,156,371	9,612,528	0	9,612,528	3,185,228	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	340,156,371	9,612,528	0	9,612,528	3,185,228	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	7,844,000	0	1.00
2.00	Land Improvements	10,195,920	4,631,030	2.00
3.00	Buildings and Fixtures	240,634,326	122,911,048	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	87,909,425	54,263,390	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	346,583,671	181,805,468	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	346,583,671	181,805,468	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2018 12:53 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	NEW CAP REL COSTS-BLDG & FIXT	5,738,865	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,738,865	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,738,865		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	5,738,865		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2018 12:53 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	NEW CAP REL COSTS-BLDG & FIXT	258,711,924	0	258,711,924	0.746382	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	87,909,425	0	87,909,425	0.253618	0	2.00
3.00	Total (sum of lines 1-2)	346,621,349	0	346,621,349	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	5,891,308	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	5,585,705	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	11,477,013	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	5,891,308	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,585,705	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	11,477,013	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 12:53 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,930,863			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	-4,152,308			0	12.00
13.00	Laundry and linen service	B	-219,161	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	B	-223,968	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-125,266	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,154	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)	B	-134,000	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	MISCELLANEOUS INCOME	B	-2,935	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.03	MISCELLANEOUS INCOME	B	-159,990	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MISCELLANEOUS INCOME	B	-3,303	OPERATION OF PLANT	7.00	0	33.04

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/24/2018 12:53 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	
33.08	MISCELLANEOUS INCOME	B	-38,820	HOUSEKEEPING	9.00	0	33.08
33.09	MISCELLANEOUS INCOME	B	-17,951	NURSING ADMINISTRATION	13.00	0	33.09
33.10	MISCELLANEOUS INCOME	B	0	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.10
33.19	MISCELLANEOUS INCOME	B	-8,075	CLINICAL PASTORAL EDUCATION	23.00	0	33.19
33.20	MISCELLANEOUS INCOME	B	-5	CARDIAC REHABILITATION	76.97	0	33.20
33.21	MISCELLANEOUS INCOME	B	-4,393	NURSERY	43.00	0	33.21
33.22	MISCELLANEOUS INCOME	B	-39,908	OPERATING ROOM	50.00	0	33.22
33.24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.24
33.25	MISCELLANEOUS INCOME	B	-285,655	LABORATORY	60.00	0	33.25
33.28	MISCELLANEOUS INCOME	B	-64,562	PHYSICAL THERAPY	66.00	0	33.28
34.00	MISCELLANEOUS INCOME	B	-6,633	CLINIC	90.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
35.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.01
35.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.02
35.03	INTEREST EXPENSE	A	-2,709,657	INTEREST EXPENSE	113.00	11	35.03
35.04	PA ASSESSMENT EXPENSE	A	-8,080,607	ADMINISTRATIVE & GENERAL	5.00	0	35.04
35.05	CONTRIBUTIONS	A	-16,458	ADMINISTRATIVE & GENERAL	5.00	0	35.05
35.06	SELF INSURANCE EXPENSE	A	-2,825,589	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.06
35.07	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.07
35.08	NON ALLOWABLE EXPENSES	A	-1,040,939	ADMINISTRATIVE & GENERAL	5.00	0	35.08
35.09	NON ALLOWABLE EXPENSES	A	-631	OPERATION OF PLANT	7.00	0	35.09
36.00	NON ALLOWABLE EXPENSES	A	-3,828	DIETARY	10.00	0	36.00
36.01	NON ALLOWABLE EXPENSES	A	-158	PHARMACY	15.00	0	36.01
36.02	NON ALLOWABLE EXPENSES	A	-49	MEDICAL RECORDS & LIBRARY	16.00	0	36.02
36.03	NON ALLOWABLE EXPENSES	A	-6,289	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	36.03
36.04	NON ALLOWABLE EXPENSES	A	-1,635	CLINICAL PASTORAL EDUCATION	23.00	0	36.04
36.05	NON ALLOWABLE EXPENSES	A	-23,427	ADULTS & PEDIATRICS	30.00	0	36.05
36.06	NON ALLOWABLE EXPENSES	A	-1,000	NURSING ADMINISTRATION	13.00	0	36.06
36.07	NON ALLOWABLE EXPENSES	A	-5,448	INTENSIVE CARE UNIT	31.00	0	36.07
36.09	NON ALLOWABLE EXPENSES	A	-4,711	EMERGENCY	91.00	0	36.09
36.10	NON ALLOWABLE EXPENSES	A	-115,466	ADMINISTRATIVE & GENERAL	5.00	0	36.10
36.11	NON ALLOWABLE EXPENSES	A	-6	CENTRAL SERVICES & SUPPLY	14.00	0	36.11
36.13	NON ALLOWABLE EXPENSES	A	-85	PHYSICAL THERAPY	66.00	0	36.13
36.14	NON ALLOWABLE EXPENSES	A	-124	SUBPROVIDER - IRF	41.00	0	36.14
36.15	MARKETING OFFSET	A	-59,223	ADMINISTRATIVE & GENERAL	5.00	0	36.15
36.16	EUREKA UNDERALLOCATION	A	-205,324	ADMINISTRATIVE & GENERAL	5.00	0	36.16
36.17	LOBBYING FEES	A	645	ADMINISTRATIVE & GENERAL	5.00	0	36.17
36.18	NON ALLOWABLE EXPENSES	A	-7,900	OPERATING ROOM	50.00	0	36.18
36.19	NON ALLOWABLE EXPENSES	A	-36	SPEECH PATHOLOGY	68.00	0	36.19
37.00	NON ALLOWABLE EXPENSES	A	-286	CARDIAC REHABILITATION	76.97	0	37.00
38.00	NON ALLOWABLE EXPENSES	A	-749	CLINIC	90.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
44.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.02
44.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.03
44.04	ADJ BOOK TO MC DEPR	A	-178,762	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	44.04
44.05	ADJ BOOK TO MC DEPR	A	-22,439	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	44.05
45.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-29,729,131				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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2018 12:53 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	54.00	RADIOLOGY-DIAGNOSTIC	ADVANCED MRI	82,721	79,020	1.00
2.00	0.00			0	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BUILDING RENTAL	43,434	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	BUILDING RENTAL	46,534	18,780	3.01
3.02	11.00	CAFETERIA	BUILDING RENTAL	4,356	0	3.02
3.03	22.00	I&R SERVICES-OTHER PRGM COST	BUILDING RENTAL	32,854	0	3.03
3.04	54.00	RADIOLOGY-DIAGNOSTIC	BUILDING RENTAL	22,662	49,800	3.04
3.05	57.00	CT SCAN	BUILDING RENTAL	37,551	19,020	3.05
3.06	60.00	LABORATORY	BUILDING RENTAL	26,467	41,568	3.06
3.07	66.00	PHYSICAL THERAPY	BUILDING RENTAL	149,266	141,828	3.07
3.08	67.00	OCCUPATIONAL THERAPY	BUILDING RENTAL	15,241	0	3.08
3.09	68.00	SPEECH PATHOLOGY	BUILDING RENTAL	11,695	0	3.09
3.10	90.00	CLINIC	BUILDING RENTAL	59,321	0	3.10
3.11	90.04	WOUND CARE CLINIC	BUILDING RENTAL	39,841	0	3.11
3.12	190.01	OTHER NONREIMBURSABLE	BUILDING RENTAL	147,411	6,780	3.12
3.13	0.00			0	0	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
4.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE	331,205	0	4.00
4.01	2.00	NEW CAP REL COSTS-MVBLE EQUI	HOME OFFICE	891,185	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2,671,441	0	4.02
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	5,085,032	13,493,729	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
5.00	0		0	9,698,217	13,850,525	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	C		0.00	ADVANCED MRI	42.80	6.00
7.00	B		0.00	ADVOCATE HEALTH	100.00	7.00
8.00			0.00		0.00	8.00
9.00	B		0.00	ADVOCATE HEALTH CARE	100.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/24/2018 12:53 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	3,701	0		1.00
2.00	0	0		2.00
3.00	43,434	0		3.00
3.01	27,754	0		3.01
3.02	4,356	0		3.02
3.03	32,854	0		3.03
3.04	-27,138	0		3.04
3.05	18,531	0		3.05
3.06	-15,101	0		3.06
3.07	7,438	0		3.07
3.08	15,241	0		3.08
3.09	11,695	0		3.09
3.10	59,321	0		3.10
3.11	39,841	0		3.11
3.12	140,631	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
4.00	331,205	9		4.00
4.01	891,185	9		4.01
4.02	2,671,441	0		4.02
4.03	-8,408,697	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
5.00	-4,152,308			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	MRI SERVICES		6.00
7.00	SAME PARENT CO		7.00
8.00			8.00
9.00	HOME OFFICE		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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2018 12:53 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	294,500	294,500	0	171,400	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	2,639,126	2,639,126	0	171,400	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	151,939	151,939	0	171,400	0	3.00
4.00	50.00	OPERATING ROOM	1,981,235	1,981,235	0	171,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,086,048	1,086,048	0	171,400	0	5.00
6.00	57.00	CT SCAN	10,220	10,220	0	171,400	0	6.00
7.00	91.00	EMERGENCY	2,767,795	2,767,795	0	171,400	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,930,863	8,930,863	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	57.00	CT SCAN	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	294,500		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	2,639,126		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	151,939		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,981,235		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,086,048		5.00
6.00	57.00	CT SCAN	0	0	0	10,220		6.00
7.00	91.00	EMERGENCY	0	0	0	2,767,795		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	8,930,863		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	5,891,308	5,891,308				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	5,585,705		5,585,705			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,841,099	39,349	3,074	10,883,522		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,959,507	562,367	566,499	1,538,260	22,626,633	5.00
7.00	00700	OPERATION OF PLANT	5,650,385	1,415,975	84,325	190,008	7,340,693	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	394,421	104,623	20,081	60,344	579,469	8.00
9.00	00900	HOUSEKEEPING	1,991,579	80,911	23,723	240,213	2,336,426	9.00
10.00	01000	DIETARY	1,012,462	38,190	11,749	98,570	1,160,971	10.00
11.00	01100	CAFETERIA	755,761	66,944	11,275	94,602	928,582	11.00
13.00	01300	NURSING ADMINISTRATION	2,105,960	53,689	6,508	362,596	2,528,753	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	685,635	59,795	52,305	63,230	860,965	14.00
15.00	01500	PHARMACY	8,450,082	51,689	205,377	428,935	9,136,083	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,667,034	58,827	3,900	228,420	1,958,181	16.00
17.00	01700	SOCIAL SERVICE	1,573,269	12,733	0	238,103	1,824,105	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,551,889	0	0	295,447	1,847,336	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	503,979	29,765	157	0	533,901	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	252,529	33,126	0	39,141	324,796	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,877,295	1,002,315	519,898	1,761,220	15,160,728	30.00
31.00	03100	INTENSIVE CARE UNIT	3,942,196	252,201	320,201	621,919	5,136,517	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,103,001	118,101	15,092	180,402	1,416,596	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,015,244	55,274	218,461	478,199	2,767,178	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,914,369	314,730	740,277	742,112	7,711,488	50.00
51.00	05100	RECOVERY ROOM	632,894	27,648	21,234	111,107	792,883	51.00
53.00	05300	ANESTHESIOLOGY	78,154	5,532	58,722	6,251	148,659	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,587,881	155,471	1,166,500	416,093	4,325,945	54.00
57.00	05700	CT SCAN	612,777	51,795	365,134	79,178	1,108,884	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,918,644	161,918	137,909	382,890	3,601,361	60.00
64.00	06400	INTRAVENOUS THERAPY	1,634,225	109,048	97,851	246,202	2,087,326	64.00
65.00	06500	RESPIRATORY THERAPY	953,224	51,753	85,158	165,627	1,255,762	65.00
66.00	06600	PHYSICAL THERAPY	1,680,875	146,142	28,270	276,370	2,131,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	454,241	13,808	0	77,325	545,374	67.00
68.00	06800	SPEECH PATHOLOGY	271,195	10,595	0	45,349	327,139	68.00
69.00	06900	ELECTROCARDIOLOGY	2,195,243	114,303	626,963	353,818	3,290,327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	152,163	10,351	9,897	16,639	189,050	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,805,728	0	0	0	10,805,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,511,295	0	0	0	9,511,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	391,198	28,775	10,664	68,060	498,697	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	642,175	53,742	1,689	98,158	795,764	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	1,040,888	39,902	961	94,407	1,176,158	90.04
91.00	09100	EMERGENCY	4,017,564	176,407	161,741	612,552	4,968,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,305,073	5,507,794	5,575,595	10,711,747	133,739,674	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	937,067	123,526	7,564	80,237	1,148,394	190.00
190.01	19001	OTHER NONREIMBURSABLE	1,999,594	259,988	2,546	91,538	2,353,666	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	137,241,734	5,891,308	5,585,705	10,883,522	137,241,734	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 12:53 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,626,633					5.00
7.00	00700	OPERATION OF PLANT	1,449,156	8,789,849				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,395	237,406	931,270			8.00
9.00	00900	HOUSEKEEPING	461,243	183,600	97,039	3,078,308		9.00
10.00	01000	DIETARY	229,192	86,658	4,147	0	1,480,968	10.00
11.00	01100	CAFETERIA	183,315	151,906	3,219	86,508	0	11.00
13.00	01300	NURSING ADMINISTRATION	499,211	121,829	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	169,967	135,684	0	82,778	0	14.00
15.00	01500	PHARMACY	1,803,591	117,291	0	84,507	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	386,572	133,488	0	3,229	0	16.00
17.00	01700	SOCIAL SERVICE	360,104	28,894	0	9,642	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	364,690	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	105,400	67,541	0	10,597	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	64,119	75,168	0	9,642	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,992,947	2,274,411	316,343	1,215,113	1,270,409	30.00
31.00	03100	INTENSIVE CARE UNIT	1,014,020	572,284	56,998	44,209	72,721	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	279,656	267,990	26,842	48,303	137,838	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	546,280	125,425	7,245	49,212	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,522,356	714,172	131,841	444,229	0	50.00
51.00	05100	RECOVERY ROOM	156,526	62,737	1,844	48,303	0	51.00
53.00	05300	ANESTHESIOLOGY	29,347	12,552	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	854,002	352,789	23,307	96,560	0	54.00
57.00	05700	CT SCAN	218,909	117,532	9,252	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	710,959	367,417	712	96,560	0	60.00
64.00	06400	INTRAVENOUS THERAPY	412,067	247,447	3,082	94,376	0	64.00
65.00	06500	RESPIRATORY THERAPY	247,905	117,436	0	9,642	0	65.00
66.00	06600	PHYSICAL THERAPY	420,819	331,620	26,098	48,166	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	107,664	31,332	153	2,593	0	67.00
68.00	06800	SPEECH PATHOLOGY	64,582	24,042	0	955	0	68.00
69.00	06900	ELECTROCARDIOLOGY	649,557	259,372	11,596	57,945	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,321	23,487	1,970	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,133,202	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,877,663	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	98,450	65,296	103	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	157,095	121,949	39	24,060	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	232,190	90,545	10,008	64,722	0	90.04
91.00	09100	EMERGENCY	980,805	400,295	199,432	386,284	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	21,935,277	7,919,595	931,270	3,018,135	1,480,968	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	226,709	280,300	0	56,398	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	464,647	589,954	0	3,775	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	22,626,633	8,789,849	931,270	3,078,308	1,480,968	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 12:53 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	1,353,530					11.00
13.00	01300	NURSING ADMINISTRATION	47,748	3,197,541				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,537	0	1,266,931			14.00
15.00	01500	PHARMACY	44,933	0	22,448	11,208,853		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	42,712	21,378	1,689	0	2,547,249	16.00
17.00	01700	SOCIAL SERVICE	30,230	121,769	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	49,203	0	10,573	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	7,849	0	13,192	0	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	282,598	1,064,846	180,776	10,888	106,708	30.00
31.00	03100	INTENSIVE CARE UNIT	97,486	391,121	54,772	4,251	28,577	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	29,904	120,317	9,708	74	14,268	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	73,517	295,664	41,981	2,403	29,574	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	109,988	440,866	89,262	263,054	356,370	50.00
51.00	05100	RECOVERY ROOM	13,306	53,419	701	4,620	21,148	51.00
53.00	05300	ANESTHESIOLOGY	1,455	5,893	2,677	57,978	40,722	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,940	544	29,087	7,053	221,920	54.00
57.00	05700	CT SCAN	11,793	0	725	36,139	245,149	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	74,014	2,807	39,137	550	303,919	60.00
64.00	06400	INTRAVENOUS THERAPY	39,783	154,321	20,870	1,381	11,830	64.00
65.00	06500	RESPIRATORY THERAPY	29,579	4,148	4,188	6,628	20,923	65.00
66.00	06600	PHYSICAL THERAPY	35,935	7,804	13,668	2,448	35,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,606	0	0	0	8,259	67.00
68.00	06800	SPEECH PATHOLOGY	5,878	0	96	0	2,318	68.00
69.00	06900	ELECTROCARDIOLOGY	46,350	25,523	46,469	172,780	198,610	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,049	1,422	89	0	4,867	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,096	0	0	96	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	3,607	0	0	85	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,704	0	8,727,278	315,043	73.00
76.97	07697	CARDIAC REHABILITATION	10,817	2,133	6,949	11	6,091	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	15,010	13,867	6,398	6,693	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	13,976	21,489	6,895	5,855	51,715	90.04
91.00	09100	EMERGENCY	100,090	431,651	103,739	215,411	523,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,309,286	3,196,389	706,089	9,525,495	2,547,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,903	0	510,802	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	18,341	1,152	50,040	1,683,358	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,353,530	3,197,541	1,266,931	11,208,853	2,547,249	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			17.00	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	2,374,744					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	2,212,026				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		777,215			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			494,766		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	937,506	2,212,026	777,215	273,874	0	30.00
31.00	03100	INTENSIVE CARE UNIT	515,897	0	0	66,428	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	228,988	0	0	10,404	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	18,858	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	83,715	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	320	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	11,525	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	11,449	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	662,046	0	0	30,573	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,374,744	2,212,026	777,215	476,839	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	0	0	0	17,927	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 12:53 pm

	Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
		17.00	21.00	22.00	23.00	23.01	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,374,744	2,212,026	777,215	494,766	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	CLINICAL PASTORAL EDUCATION					23.00
23.01	02301	EMS PROGRAM					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	29,076,388	-2,989,241	26,087,147		30.00
31.00	03100	INTENSIVE CARE UNIT	8,055,281	0	8,055,281		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	2,590,888	0	2,590,888		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	3,957,337	0	3,957,337		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	11,867,341	0	11,867,341		50.00
51.00	05100	RECOVERY ROOM	1,155,487	0	1,155,487		51.00
53.00	05300	ANESTHESIOLOGY	299,283	0	299,283		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,976,467	0	5,976,467		54.00
57.00	05700	CT SCAN	1,748,383	0	1,748,383		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	5,197,436	0	5,197,436		60.00
64.00	06400	INTRAVENOUS THERAPY	3,072,483	0	3,072,483		64.00
65.00	06500	RESPIRATORY THERAPY	1,696,211	0	1,696,211		65.00
66.00	06600	PHYSICAL THERAPY	3,053,769	0	3,053,769		66.00
67.00	06700	OCCUPATIONAL THERAPY	705,981	0	705,981		67.00
68.00	06800	SPEECH PATHOLOGY	425,010	0	425,010		68.00
69.00	06900	ELECTROCARDIOLOGY	4,770,054	0	4,770,054		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	260,255	0	260,255		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,943,122	0	12,943,122		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,392,650	0	11,392,650		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,050,025	0	9,050,025		73.00
76.97	07697	CARDIAC REHABILITATION	688,547	0	688,547		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1,152,324	0	1,152,324		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0		90.03
90.04	09003	WOUND CARE CLINIC	1,673,553	0	1,673,553		90.04
91.00	09100	EMERGENCY	9,002,093	0	9,002,093		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,810,368	-2,989,241	126,821,127		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,248,506	0	2,248,506		190.00
190.01	19001	OTHER NONREIMBURSABLE	5,182,860	0	5,182,860		190.01
190.13	19007	EUREKA	0	0	0		190.13
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/24/2018 12:53 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	137,241,734	-2,989,241	134,252,493		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	39,349	3,074	42,423	42,423	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	37,766	562,367	566,499	1,166,632	5,992	5.00
7.00	00700	OPERATION OF PLANT	2,599	1,415,975	84,325	1,502,899	740	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,048	104,623	20,081	147,752	235	8.00
9.00	00900	HOUSEKEEPING	0	80,911	23,723	104,634	936	9.00
10.00	01000	DIETARY	31,477	38,190	11,749	81,416	384	10.00
11.00	01100	CAFETERIA	0	66,944	11,275	78,219	369	11.00
13.00	01300	NURSING ADMINISTRATION	0	53,689	6,508	60,197	1,413	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,795	52,305	112,100	246	14.00
15.00	01500	PHARMACY	0	51,689	205,377	257,066	1,671	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,681	58,827	3,900	92,408	890	16.00
17.00	01700	SOCIAL SERVICE	0	12,733	0	12,733	928	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,151	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	36,506	29,765	157	66,428	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	33,126	0	33,126	152	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	202,885	1,002,315	519,898	1,725,098	6,885	30.00
31.00	03100	INTENSIVE CARE UNIT	82,652	252,201	320,201	655,054	2,423	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	17,292	118,101	15,092	150,485	703	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	55,274	218,461	273,735	1,863	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,158	314,730	740,277	1,056,165	2,891	50.00
51.00	05100	RECOVERY ROOM	0	27,648	21,234	48,882	433	51.00
53.00	05300	ANESTHESIOLOGY	0	5,532	58,722	64,254	24	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,820	155,471	1,166,500	1,450,791	1,621	54.00
57.00	05700	CT SCAN	19,020	51,795	365,134	435,949	308	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	59,395	161,918	137,909	359,222	1,492	60.00
64.00	06400	INTRAVENOUS THERAPY	0	109,048	97,851	206,899	959	64.00
65.00	06500	RESPIRATORY THERAPY	0	51,753	85,158	136,911	645	65.00
66.00	06600	PHYSICAL THERAPY	149,813	146,142	28,270	324,225	1,077	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,808	0	13,808	301	67.00
68.00	06800	SPEECH PATHOLOGY	0	10,595	0	10,595	177	68.00
69.00	06900	ELECTROCARDIOLOGY	0	114,303	626,963	741,266	1,378	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,351	9,897	20,248	65	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	28,775	10,664	39,439	265	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	53,742	1,689	55,431	382	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	39,902	961	40,863	368	90.04
91.00	09100	EMERGENCY	0	176,407	161,741	338,148	2,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	822,112	5,507,794	5,575,595	11,905,501	41,753	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	123,526	7,564	131,090	313	190.00
190.01	19001	OTHER NONREIMBURSABLE	6,780	259,988	2,546	269,314	357	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 12:53 pm

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	828,892	5,891,308	5,585,705	12,305,905	42,423	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 12:53 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,172,624					5.00
7.00	00700	OPERATION OF PLANT	75,103	1,578,742				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,929	42,640	196,556			8.00
9.00	00900	HOUSEKEEPING	23,904	32,976	20,481	182,931		9.00
10.00	01000	DIETARY	11,878	15,565	875	0	110,118	10.00
11.00	01100	CAFETERIA	9,500	27,284	679	5,141	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,872	21,882	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,809	24,370	0	4,919	0	14.00
15.00	01500	PHARMACY	93,471	21,067	0	5,022	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,034	23,976	0	192	0	16.00
17.00	01700	SOCIAL SERVICE	18,662	5,190	0	573	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	18,900	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	5,462	12,131	0	630	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	3,323	13,501	0	573	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	155,108	408,503	66,770	72,211	94,462	30.00
31.00	03100	INTENSIVE CARE UNIT	52,552	102,788	12,030	2,627	5,407	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	14,493	48,134	5,665	2,870	10,249	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	28,311	22,528	1,529	2,924	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	78,896	128,272	27,827	26,399	0	50.00
51.00	05100	RECOVERY ROOM	8,112	11,268	389	2,870	0	51.00
53.00	05300	ANESTHESIOLOGY	1,521	2,254	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,259	63,364	4,919	5,738	0	54.00
57.00	05700	CT SCAN	11,345	21,110	1,953	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	36,846	65,992	150	5,738	0	60.00
64.00	06400	INTRAVENOUS THERAPY	21,355	44,444	651	5,608	0	64.00
65.00	06500	RESPIRATORY THERAPY	12,848	21,093	0	573	0	65.00
66.00	06600	PHYSICAL THERAPY	21,809	59,562	5,508	2,862	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,580	5,628	32	154	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,347	4,318	0	57	0	68.00
69.00	06900	ELECTROCARDIOLOGY	33,663	46,586	2,447	3,443	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,934	4,219	416	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,553	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	97,310	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	5,102	11,728	22	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	8,141	21,903	8	1,430	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	12,033	16,263	2,112	3,846	0	90.04
91.00	09100	EMERGENCY	50,830	71,897	42,093	22,955	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,136,795	1,422,436	196,556	179,355	110,118	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,749	50,345	0	3,352	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	24,080	105,961	0	224	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,172,624	1,578,742	196,556	182,931	110,118	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 12:53 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	121,192					11.00
13.00	01300	NURSING ADMINISTRATION	4,275	113,639				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,570	0	152,014			14.00
15.00	01500	PHARMACY	4,023	0	2,693	385,013		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,824	760	203	0	142,287	16.00
17.00	01700	SOCIAL SERVICE	2,707	4,328	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,405	0	1,269	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	703	0	1,583	0	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,304	37,844	21,691	374	5,961	30.00
31.00	03100	INTENSIVE CARE UNIT	8,729	13,900	6,572	146	1,596	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,678	4,276	1,165	3	797	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	6,583	10,508	5,037	83	1,652	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,848	15,668	10,710	9,036	19,907	50.00
51.00	05100	RECOVERY ROOM	1,191	1,898	84	159	1,181	51.00
53.00	05300	ANESTHESIOLOGY	130	209	321	1,992	2,275	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,815	19	3,490	242	12,396	54.00
57.00	05700	CT SCAN	1,056	0	87	1,241	13,694	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,627	100	4,696	19	16,977	60.00
64.00	06400	INTRAVENOUS THERAPY	3,562	5,484	2,504	47	661	64.00
65.00	06500	RESPIRATORY THERAPY	2,648	147	503	228	1,169	65.00
66.00	06600	PHYSICAL THERAPY	3,218	277	1,640	84	1,986	66.00
67.00	06700	OCCUPATIONAL THERAPY	950	0	0	0	461	67.00
68.00	06800	SPEECH PATHOLOGY	526	0	11	0	129	68.00
69.00	06900	ELECTROCARDIOLOGY	4,150	907	5,576	5,935	11,094	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	183	51	11	0	272	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	146	0	0	5	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	128	0	0	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	274	0	299,772	17,598	73.00
76.97	07697	CARDIAC REHABILITATION	969	76	834	0	340	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,344	493	768	230	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	1,251	764	827	201	2,889	90.04
91.00	09100	EMERGENCY	8,962	15,341	12,447	7,399	29,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,231	113,598	84,722	327,191	142,287	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,319	0	61,288	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	1,642	41	6,004	57,822	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	121,192	113,639	152,014	385,013	142,287	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
			17.00	21.00	22.00	23.00	23.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	45,121					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	20,051				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		90,325			22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0			52,961		23.00
23.01	02301	EMS PROGRAM	0				0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,813					30.00
31.00	03100	INTENSIVE CARE UNIT	9,802					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
41.00	04100	SUBPROVIDER - IRF	4,351					41.00
42.00	04200	SUBPROVIDER	0					42.00
43.00	04300	NURSERY	358					43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0					50.00
51.00	05100	RECOVERY ROOM	0					51.00
53.00	05300	ANESTHESIOLOGY	0					53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0					54.00
57.00	05700	CT SCAN	0					57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
59.00	05900	CARDIAC CATHETERIZATION	0					59.00
60.00	06000	LABORATORY	0					60.00
64.00	06400	INTRAVENOUS THERAPY	0					64.00
65.00	06500	RESPIRATORY THERAPY	0					65.00
66.00	06600	PHYSICAL THERAPY	0					66.00
67.00	06700	OCCUPATIONAL THERAPY	0					67.00
68.00	06800	SPEECH PATHOLOGY	0					68.00
69.00	06900	ELECTROCARDIOLOGY	0					69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0					70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0					73.00
76.97	07697	CARDIAC REHABILITATION	0					76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	218					90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0					90.01
90.03	09002	PSYCH OUTPATIENT	0					90.03
90.04	09003	WOUND CARE CLINIC	0					90.04
91.00	09100	EMERGENCY	12,579					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0					93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0					99.10
101.00	10100	HOME HEALTH AGENCY	0					101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0					109.00
110.00	11000	INTESTINAL ACQUISITION	0					110.00
111.00	11100	ISLET ACQUISITION	0					111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,121	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
190.01	19001	OTHER NONREIMBURSABLE	0					190.01
190.13	19007	EUREKA	0					190.13
191.00	19100	RESEARCH	0					191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0					192.00
200.00		Cross Foot Adjustments		20,051	90,325	52,961	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 12:53 pm

	Cost Center Description	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	CLINICAL PASTORAL EDUCATION	EMS PROGRAM	
		17.00	21.00	22.00	23.00	23.01	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	45,121	20,051	90,325	52,961	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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					17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD					22.00
23.00	02300	CLINICAL PASTORAL EDUCATION					23.00
23.01	02301	EMS PROGRAM					23.01
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,638,024	0	2,638,024		30.00
31.00	03100	INTENSIVE CARE UNIT	873,626	0	873,626		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	245,869	0	245,869		41.00
42.00	04200	SUBPROVIDER	0	0	0		42.00
43.00	04300	NURSERY	355,111	0	355,111		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,385,619	0	1,385,619		50.00
51.00	05100	RECOVERY ROOM	76,467	0	76,467		51.00
53.00	05300	ANESTHESIOLOGY	72,980	0	72,980		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,592,654	0	1,592,654		54.00
57.00	05700	CT SCAN	486,743	0	486,743		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	497,859	0	497,859		60.00
64.00	06400	INTRAVENOUS THERAPY	292,174	0	292,174		64.00
65.00	06500	RESPIRATORY THERAPY	176,765	0	176,765		65.00
66.00	06600	PHYSICAL THERAPY	422,248	0	422,248		66.00
67.00	06700	OCCUPATIONAL THERAPY	26,914	0	26,914		67.00
68.00	06800	SPEECH PATHOLOGY	19,160	0	19,160		68.00
69.00	06900	ELECTROCARDIOLOGY	856,445	0	856,445		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,399	0	27,399		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,704	0	110,704		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	97,443	0	97,443		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,644	0	317,644		73.00
76.97	07697	CARDIAC REHABILITATION	58,775	0	58,775		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	90,348	0	90,348		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0		90.03
90.04	09003	WOUND CARE CLINIC	81,417	0	81,417		90.04
91.00	09100	EMERGENCY	614,279	0	614,279		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,416,667	0	11,416,667		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	260,456	0	260,456		190.00
190.01	19001	OTHER NONREIMBURSABLE	465,445	0	465,445		190.01
190.13	19007	EUREKA	0	0	0		190.13
191.00	19100	RESEARCH	0	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
200.00		Cross Foot Adjustments	163,337	0	163,337		200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/24/2018 12:53 pm

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
201.00	Negative Cost Centers	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	12,305,905	0	12,305,905		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	553,809					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		4,732,017				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,699	2,604	57,449,760			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,865	479,918	8,119,865	-22,626,633	114,615,101	5.00
7.00	00700	OPERATION OF PLANT	133,108	71,437	1,002,975	0	7,340,693	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	17,012	318,533	0	579,469	8.00
9.00	00900	HOUSEKEEPING	7,606	20,097	1,267,987	0	2,336,426	9.00
10.00	01000	DIETARY	3,590	9,953	520,313	0	1,160,971	10.00
11.00	01100	CAFETERIA	6,293	9,552	499,365	0	928,582	11.00
13.00	01300	NURSING ADMINISTRATION	5,047	5,513	1,914,000	0	2,528,753	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	44,311	333,768	0	860,965	14.00
15.00	01500	PHARMACY	4,859	173,988	2,264,178	0	9,136,083	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	3,304	1,205,738	0	1,958,181	16.00
17.00	01700	SOCIAL SERVICE	1,197	0	1,256,850	0	1,824,105	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,559,549	0	1,847,336	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,798	133	0	0	533,901	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	3,114	0	206,612	0	324,796	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,222	440,440	9,296,731	0	15,160,728	30.00
31.00	03100	INTENSIVE CARE UNIT	23,708	271,263	3,282,862	0	5,136,517	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,102	12,785	952,273	0	1,416,596	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,196	185,073	2,524,222	0	2,767,178	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,586	627,137	3,917,317	0	7,711,488	50.00
51.00	05100	RECOVERY ROOM	2,599	17,989	586,489	0	792,883	51.00
53.00	05300	ANESTHESIOLOGY	520	49,747	32,997	0	148,659	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,615	988,222	2,196,393	0	4,325,945	54.00
57.00	05700	CT SCAN	4,869	309,329	417,949	0	1,108,884	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	15,221	116,832	2,021,125	0	3,601,361	60.00
64.00	06400	INTRAVENOUS THERAPY	10,251	82,896	1,299,601	0	2,087,326	64.00
65.00	06500	RESPIRATORY THERAPY	4,865	72,143	874,282	0	1,255,762	65.00
66.00	06600	PHYSICAL THERAPY	13,738	23,949	1,458,849	0	2,131,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298	0	408,170	0	545,374	67.00
68.00	06800	SPEECH PATHOLOGY	996	0	239,382	0	327,139	68.00
69.00	06900	ELECTROCARDIOLOGY	10,745	531,141	1,867,667	0	3,290,327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	8,384	87,832	0	189,050	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	10,805,728	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	9,511,295	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,705	9,034	359,260	0	498,697	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,052	1,431	518,135	0	795,764	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	3,751	814	498,338	0	1,176,158	90.04
91.00	09100	EMERGENCY	16,583	137,021	3,233,422	0	4,968,264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	517,757	4,723,452	56,543,029	-22,626,633	111,113,041	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,612	6,408	423,540	0	1,148,394	190.00
190.01	19001	OTHER NONREIMBURSABLE	24,440	2,157	483,191	0	2,353,666	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,891,308	5,585,705	10,883,522		22,626,633	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.637798	1.180407	0.189444		0.197414	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			42,423		1,172,624	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000738		0.010231	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	364,137					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,835	613,012				8.00
9.00	00900	HOUSEKEEPING	7,606	63,876	67,681			9.00
10.00	01000	DIETARY	3,590	2,730	0	32,136		10.00
11.00	01100	CAFETERIA	6,293	2,119	1,902	0	70,699	11.00
13.00	01300	NURSING ADMINISTRATION	5,047	0	0	0	2,494	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,621	0	1,820	0	916	14.00
15.00	01500	PHARMACY	4,859	0	1,858	0	2,347	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,530	0	71	0	2,231	16.00
17.00	01700	SOCIAL SERVICE	1,197	0	212	0	1,579	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	2,798	0	233	0	2,570	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	3,114	0	212	0	410	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	94,222	208,232	26,716	27,567	14,761	30.00
31.00	03100	INTENSIVE CARE UNIT	23,708	37,519	972	1,578	5,092	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,102	17,669	1,062	2,991	1,562	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,196	4,769	1,082	0	3,840	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	29,586	86,785	9,767	0	5,745	50.00
51.00	05100	RECOVERY ROOM	2,599	1,214	1,062	0	695	51.00
53.00	05300	ANESTHESIOLOGY	520	0	0	0	76	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,615	15,342	2,123	0	3,392	54.00
57.00	05700	CT SCAN	4,869	6,090	0	0	616	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	15,221	469	2,123	0	3,866	60.00
64.00	06400	INTRAVENOUS THERAPY	10,251	2,029	2,075	0	2,078	64.00
65.00	06500	RESPIRATORY THERAPY	4,865	0	212	0	1,545	65.00
66.00	06600	PHYSICAL THERAPY	13,738	17,179	1,059	0	1,877	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,298	101	57	0	554	67.00
68.00	06800	SPEECH PATHOLOGY	996	0	21	0	307	68.00
69.00	06900	ELECTROCARDIOLOGY	10,745	7,633	1,274	0	2,421	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	973	1,297	0	0	107	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	2,705	68	0	0	565	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,052	26	529	0	784	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	3,751	6,588	1,423	0	730	90.04
91.00	09100	EMERGENCY	16,583	131,277	8,493	0	5,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	328,085	613,012	66,358	32,136	68,388	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,612	0	1,240	0	1,353	190.00
190.01	19001	OTHER NONREIMBURSABLE	24,440	0	83	0	958	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	8,789,849	931,270	3,078,308	1,480,968	1,353,530	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	24.138852	1.519171	45.482602	46.084391	19.144967	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,578,742	196,556	182,931	110,118	121,192	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.335572	0.320640	2.702841	3.426624	1.714197	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITIO)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	863,322					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	925,695				14.00
15.00	01500	PHARMACY	0	16,402	7,436,176			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,772	1,234	0	3,792,506		16.00
17.00	01700	SOCIAL SERVICE	32,877	0	0	0	3,526	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	7,725	0	0	0	22.00
23.00	02300	CLINICAL PASTORAL EDUCATION	0	9,639	0	0	0	23.00
23.01	02301	EMS PROGRAM	0	0	0	0	0	23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	287,503	132,086	7,223	158,874	1,392	30.00
31.00	03100	INTENSIVE CARE UNIT	105,601	40,020	2,820	42,547	766	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	32,485	7,093	49	21,243	340	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	79,828	30,674	1,594	44,031	28	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,032	65,220	174,515	530,586	0	50.00
51.00	05100	RECOVERY ROOM	14,423	512	3,065	31,486	0	51.00
53.00	05300	ANESTHESIOLOGY	1,591	1,956	38,464	60,629	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	147	21,253	4,679	330,409	0	54.00
57.00	05700	CT SCAN	0	530	23,975	364,993	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	758	28,596	365	452,494	0	60.00
64.00	06400	INTRAVENOUS THERAPY	41,666	15,249	916	17,614	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,120	3,060	4,397	31,152	0	65.00
66.00	06600	PHYSICAL THERAPY	2,107	9,987	1,624	52,935	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	12,297	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	70	0	3,451	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,891	33,953	114,626	295,704	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	384	65	0	7,247	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,106	0	0	143	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	974	0	0	126	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,080	0	5,789,852	469,056	0	73.00
76.97	07697	CARDIAC REHABILITATION	576	5,077	7	9,069	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,744	4,675	4,440	0	17	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	5,802	5,038	3,884	76,996	0	90.04
91.00	09100	EMERGENCY	116,544	75,798	142,908	779,424	983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	863,011	515,912	6,319,403	3,792,506	3,526	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	373,221	0	0	0	190.00
190.01	19001	OTHER NONREIMBURSABLE	311	36,562	1,116,773	0	0	190.01
190.13	19007	EUREKA	0	0	0	0	0	190.13
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISITIO)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,197,541	1,266,931	11,208,853	2,547,249	2,374,744	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.703764	1.368627	1.507341	0.671653	673.495179	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	113,639	152,014	385,013	142,287	45,121	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.131630	0.164216	0.051776	0.037518	12.796653	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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						17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	100					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		100				22.00
23.00	02300	CLINICAL PASTORAL EDUCATION			3,091			23.00
23.01	02301	EMS PROGRAM				0		23.01
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100	100	1,711	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	415	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0	65	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	523	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2	0		54.00
57.00	05700	CT SCAN	0	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	72	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0		90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0		90.04
91.00	09100	EMERGENCY	0	0	191	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0		111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	2,979	0		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01	19001	OTHER NONREIMBURSABLE	0	0	112	0		190.01
190.13	19007	EUREKA	0	0	0	0		190.13
191.00	19100	RESEARCH	0	0	0	0		191.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/24/2018 12:53 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	CLINICAL PASTORAL EDUCATION (ASSIGNED TIME)	EMS PROGRAM (ASSIGNED TIME)		
			21.00	22.00	23.00	23.01		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,212,026	777,215	494,766	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	22,120.260000	7,772.150000	160.066645	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,051	90,325	52,961	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	200.510000	903.250000	17.133937	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)			0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,087,147		26,087,147	0	26,087,147	30.00
31.00	03100	INTENSIVE CARE UNIT	8,055,281		8,055,281	0	8,055,281	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,590,888		2,590,888	0	2,590,888	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	3,957,337		3,957,337	0	3,957,337	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,867,341		11,867,341	0	11,867,341	50.00
51.00	05100	RECOVERY ROOM	1,155,487		1,155,487	0	1,155,487	51.00
53.00	05300	ANESTHESIOLOGY	299,283		299,283	0	299,283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,976,467		5,976,467	0	5,976,467	54.00
57.00	05700	CT SCAN	1,748,383		1,748,383	0	1,748,383	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	5,197,436		5,197,436	0	5,197,436	60.00
64.00	06400	INTRAVENOUS THERAPY	3,072,483		3,072,483	0	3,072,483	64.00
65.00	06500	RESPIRATORY THERAPY	1,696,211	0	1,696,211	0	1,696,211	65.00
66.00	06600	PHYSICAL THERAPY	3,053,769	0	3,053,769	0	3,053,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	705,981	0	705,981	0	705,981	67.00
68.00	06800	SPEECH PATHOLOGY	425,010	0	425,010	0	425,010	68.00
69.00	06900	ELECTROCARDIOLOGY	4,770,054		4,770,054	0	4,770,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	260,255		260,255	0	260,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,943,122		12,943,122	0	12,943,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,392,650		11,392,650	0	11,392,650	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,050,025		9,050,025	0	9,050,025	73.00
76.97	07697	CARDIAC REHABILITATION	688,547		688,547	0	688,547	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,152,324		1,152,324	0	1,152,324	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0		0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	1,673,553		1,673,553	0	1,673,553	90.04
91.00	09100	EMERGENCY	9,002,093		9,002,093	0	9,002,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,514,121		3,514,121		3,514,121	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	130,335,248	0	130,335,248	0	130,335,248	200.00
201.00		Less Observation Beds	3,514,121		3,514,121		3,514,121	201.00
202.00		Total (see instructions)	126,821,127	0	126,821,127	0	126,821,127	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I | Date/Time Prepared: 5/24/2018 12:53 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	37,544,129		37,544,129			30.00
31.00	03100	INTENSIVE CARE UNIT	11,086,068		11,086,068			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	2,853,680		2,853,680			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	13,261,751		13,261,751			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,092,233	22,622,197	41,714,430	0.284490	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,604,718	2,079,204	3,683,922	0.313657	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,728,101	3,778,349	7,506,450	0.039870	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,516,272	27,460,061	34,976,333	0.170872	0.000000	54.00
57.00	05700	CT SCAN	10,162,234	29,017,862	39,180,096	0.044624	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	22,522,616	30,078,507	52,601,123	0.098808	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	907,819	4,997,908	5,905,727	0.520255	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,554,697	612,828	4,167,525	0.407007	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,951,939	3,342,463	6,294,402	0.485156	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,153,235	319,769	2,473,004	0.285475	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	519,394	119,727	639,121	0.664991	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,317,331	16,487,021	26,804,352	0.177958	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	227,543	603,243	830,786	0.313264	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,867,092	4,425,011	10,292,103	1.257578	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,638,318	8,652,278	27,290,596	0.417457	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,850,662	27,348,546	73,199,208	0.123636	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	28,511	743,542	772,053	0.891839	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,151,455	1,151,455	1.000755	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0.000000	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	367,332	6,345,570	6,712,902	0.249304	0.000000	90.04
91.00	09100	EMERGENCY	7,449,224	25,786,765	33,235,989	0.270854	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,335,800	3,895,215	5,231,015	0.671786	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	229,540,699	219,867,521	449,408,220			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	229,540,699	219,867,521	449,408,220			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 12:53 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
41.00	04100	SUBPROVIDER - IRF		41.00
42.00	04200	SUBPROVIDER		42.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.284490	50.00
51.00	05100	RECOVERY ROOM	0.313657	51.00
53.00	05300	ANESTHESIOLOGY	0.039870	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170872	54.00
57.00	05700	CT SCAN	0.044624	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.098808	60.00
64.00	06400	INTRAVENOUS THERAPY	0.520255	64.00
65.00	06500	RESPIRATORY THERAPY	0.407007	65.00
66.00	06600	PHYSICAL THERAPY	0.485156	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285475	67.00
68.00	06800	SPEECH PATHOLOGY	0.664991	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177958	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.313264	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.257578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417457	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123636	73.00
76.97	07697	CARDIAC REHABILITATION	0.891839	76.97
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	1.000755	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0.249304	90.04
91.00	09100	EMERGENCY	0.270854	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.671786	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
109.00	10900	PANCREAS ACQUISITION		109.00
110.00	11000	INTESTINAL ACQUISITION		110.00
111.00	11100	ISLET ACQUISITION		111.00
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 12:53 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	26,087,147		26,087,147	0	26,087,147	30.00
31.00	03100	INTENSIVE CARE UNIT	8,055,281		8,055,281	0	8,055,281	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,590,888		2,590,888	0	2,590,888	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	3,957,337		3,957,337	0	3,957,337	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,867,341		11,867,341	0	11,867,341	50.00
51.00	05100	RECOVERY ROOM	1,155,487		1,155,487	0	1,155,487	51.00
53.00	05300	ANESTHESIOLOGY	299,283		299,283	0	299,283	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,976,467		5,976,467	0	5,976,467	54.00
57.00	05700	CT SCAN	1,748,383		1,748,383	0	1,748,383	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	5,197,436		5,197,436	0	5,197,436	60.00
64.00	06400	INTRAVENOUS THERAPY	3,072,483		3,072,483	0	3,072,483	64.00
65.00	06500	RESPIRATORY THERAPY	1,696,211	0	1,696,211	0	1,696,211	65.00
66.00	06600	PHYSICAL THERAPY	3,053,769	0	3,053,769	0	3,053,769	66.00
67.00	06700	OCCUPATIONAL THERAPY	705,981	0	705,981	0	705,981	67.00
68.00	06800	SPEECH PATHOLOGY	425,010	0	425,010	0	425,010	68.00
69.00	06900	ELECTROCARDIOLOGY	4,770,054		4,770,054	0	4,770,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	260,255		260,255	0	260,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	12,943,122		12,943,122	0	12,943,122	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	11,392,650		11,392,650	0	11,392,650	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,050,025		9,050,025	0	9,050,025	73.00
76.97	07697	CARDIAC REHABILITATION	688,547		688,547	0	688,547	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,152,324		1,152,324	0	1,152,324	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0		0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0		0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	1,673,553		1,673,553	0	1,673,553	90.04
91.00	09100	EMERGENCY	9,002,093		9,002,093	0	9,002,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,514,121		3,514,121		3,514,121	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	130,335,248	0	130,335,248	0	130,335,248	200.00
201.00		Less Observation Beds	3,514,121		3,514,121		3,514,121	201.00
202.00		Total (see instructions)	126,821,127	0	126,821,127	0	126,821,127	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 12:53 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	37,544,129		37,544,129			30.00
31.00	03100	INTENSIVE CARE UNIT	11,086,068		11,086,068			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	2,853,680		2,853,680			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	13,261,751		13,261,751			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,092,233	22,622,197	41,714,430	0.284490	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,604,718	2,079,204	3,683,922	0.313657	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,728,101	3,778,349	7,506,450	0.039870	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,516,272	27,460,061	34,976,333	0.170872	0.000000	54.00
57.00	05700	CT SCAN	10,162,234	29,017,862	39,180,096	0.044624	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	22,522,616	30,078,507	52,601,123	0.098808	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	907,819	4,997,908	5,905,727	0.520255	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,554,697	612,828	4,167,525	0.407007	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,951,939	3,342,463	6,294,402	0.485156	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,153,235	319,769	2,473,004	0.285475	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	519,394	119,727	639,121	0.664991	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,317,331	16,487,021	26,804,352	0.177958	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	227,543	603,243	830,786	0.313264	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,867,092	4,425,011	10,292,103	1.257578	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,638,318	8,652,278	27,290,596	0.417457	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,850,662	27,348,546	73,199,208	0.123636	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	28,511	743,542	772,053	0.891839	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	1,151,455	1,151,455	1.000755	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0.000000	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0.000000	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	367,332	6,345,570	6,712,902	0.249304	0.000000	90.04
91.00	09100	EMERGENCY	7,449,224	25,786,765	33,235,989	0.270854	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,335,800	3,895,215	5,231,015	0.671786	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	229,540,699	219,867,521	449,408,220			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	229,540,699	219,867,521	449,408,220			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/24/2018 12:53 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
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
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
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000		90.01
90.03	09002	PSYCH OUTPATIENT	0.000000		90.03
90.04	09003	WOUND CARE CLINIC	0.000000		90.04
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/24/2018 12:53 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	2,638,024	0	2,638,024	22,909	115.15	30.00
31.00	INTENSIVE CARE UNIT	873,626		873,626	7,352	118.83	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	245,869	0	245,869	2,723	90.29	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	355,111		355,111	4,457	79.67	43.00
200.00	Total (lines 30 through 199)	4,112,630		4,112,630	37,441		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	7,593	874,334	30.00
31.00	INTENSIVE CARE UNIT	2,816	334,625	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
41.00	SUBPROVIDER - IRF	1,585	143,110	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	11,994	1,352,069	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/24/2018 12:53 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	1,385,619	41,714,430	0.033217	8,048,227	267,338	50.00
51.00	05100	RECOVERY ROOM	76,467	3,683,922	0.020757	666,393	13,832	51.00
53.00	05300	ANESTHESIOLOGY	72,980	7,506,450	0.009722	1,405,988	13,669	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,592,654	34,976,333	0.045535	3,260,950	148,487	54.00
57.00	05700	CT SCAN	486,743	39,180,096	0.012423	4,861,624	60,396	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	497,859	52,601,123	0.009465	9,600,967	90,873	60.00
64.00	06400	INTRAVENOUS THERAPY	292,174	5,905,727	0.049473	669,290	33,112	64.00
65.00	06500	RESPIRATORY THERAPY	176,765	4,167,525	0.042415	1,536,116	65,154	65.00
66.00	06600	PHYSICAL THERAPY	422,248	6,294,402	0.067083	988,076	66,283	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,914	2,473,004	0.010883	566,196	6,162	67.00
68.00	06800	SPEECH PATHOLOGY	19,160	639,121	0.029979	94,833	2,843	68.00
69.00	06900	ELECTROCARDIOLOGY	856,445	26,804,352	0.031952	4,715,913	150,683	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,399	830,786	0.032980	104,339	3,441	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,704	10,292,103	0.010756	2,516,641	27,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	97,443	27,290,596	0.003571	8,085,621	28,874	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,644	73,199,208	0.004339	16,871,598	73,206	73.00
76.97	07697	CARDIAC REHABILITATION	58,775	772,053	0.076128	14,592	1,111	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	90,348	1,151,455	0.078464	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	81,417	6,712,902	0.012128	166,139	2,015	90.04
91.00	09100	EMERGENCY	614,279	33,235,989	0.018482	3,260,019	60,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	355,362	5,231,015	0.067934	709,962	48,231	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	7,659,399	384,662,592		68,143,484	1,163,031	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/24/2018 12:53 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	273,874	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	66,428	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	10,404	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	350,706	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	273,874	22,909	11.95	7,593	30.00
31.00	03100	INTENSIVE CARE UNIT		66,428	7,352	9.04	2,816	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	10,404	2,723	3.82	1,585	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	4,457	0.00	0	43.00
200.00		Total (lines 30 through 199)		350,706	37,441		11,994	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	90,736	30.00
31.00	03100	INTENSIVE CARE UNIT	25,457	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	6,055	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
200.00		Total (lines 30 through 199)	122,248	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/24/2018 12:53 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	83,715	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	320	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	11,525	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	30,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		36,891	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	163,024	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 12:53 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	83,715	83,715	41,714,430	0.002007	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,683,922	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,506,450	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	320	320	34,976,333	0.000009	54.00
57.00	05700	CT SCAN	0	0	0	39,180,096	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,601,123	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,905,727	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,167,525	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,294,402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,473,004	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	639,121	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,525	11,525	26,804,352	0.000430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	830,786	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,292,103	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27,290,596	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73,199,208	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	772,053	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,151,455	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	6,712,902	0.000000	90.04
91.00	09100	EMERGENCY	0	30,573	30,573	33,235,989	0.000920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	36,891	36,891	5,231,015	0.007052	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	163,024	163,024	384,662,592		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 12:53 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	0.002007	8,048,227	16,153	4,776,475	9,586	50.00
51.00	05100	RECOVERY ROOM	0.000000	666,393	0	330,943	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,405,988	0	706,844	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000009	3,260,950	29	5,931,098	53	54.00
57.00	05700	CT SCAN	0.000000	4,861,624	0	6,827,132	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	9,600,967	0	5,098,568	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	669,290	0	1,254,753	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,536,116	0	132,695	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	988,076	0	40,704	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	566,196	0	22,294	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	94,833	0	2,129	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000430	4,715,913	2,028	6,808,050	2,927	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	104,339	0	97,875	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,516,641	0	1,247,350	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	8,085,621	0	4,027,033	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,871,598	0	5,353,499	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	14,592	0	294,211	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	9,101	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.000000	166,139	0	3,046,032	0	90.04
91.00	09100	EMERGENCY	0.000920	3,260,019	2,999	4,020,638	3,699	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.007052	709,962	5,007	1,242,715	8,764	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		68,143,484	26,216	51,270,139	25,029	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 12:53 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	0.284490	4,776,475	0	0	1,358,859	50.00
51.00	05100	RECOVERY ROOM	0.313657	330,943	0	0	103,803	51.00
53.00	05300	ANESTHESIOLOGY	0.039870	706,844	0	0	28,182	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170872	5,931,098	0	0	1,013,459	54.00
57.00	05700	CT SCAN	0.044624	6,827,132	0	0	304,654	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.098808	5,098,568	193	0	503,779	60.00
64.00	06400	INTRAVENOUS THERAPY	0.520255	1,254,753	0	0	652,792	64.00
65.00	06500	RESPIRATORY THERAPY	0.407007	132,695	0	0	54,008	65.00
66.00	06600	PHYSICAL THERAPY	0.485156	40,704	0	0	19,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285475	22,294	0	0	6,364	67.00
68.00	06800	SPEECH PATHOLOGY	0.664991	2,129	0	0	1,416	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177958	6,808,050	0	0	1,211,547	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.313264	97,875	0	0	30,661	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.257578	1,247,350	0	0	1,568,640	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417457	4,027,033	0	0	1,681,113	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123636	5,353,499	0	66,773	661,885	73.00
76.97	07697	CARDIAC REHABILITATION	0.891839	294,211	0	0	262,389	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.000755	9,101	0	0	9,108	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.249304	3,046,032	0	0	759,388	90.04
91.00	09100	EMERGENCY	0.270854	4,020,638	0	0	1,089,006	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.671786	1,242,715	0	0	834,839	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		51,270,139	193	66,773	12,155,640	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		51,270,139	193	66,773	12,155,640	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 12:53 pm

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		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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	19	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,256		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0		90.03
90.04	09003	WOUND CARE CLINIC	0	0		90.04
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
200.00		Subtotal (see instructions)	19	8,256		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	19	8,256		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | 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	1,385,619	41,714,430	0.033217	8,880	295	50.00
51.00	05100	RECOVERY ROOM	76,467	3,683,922	0.020757	730	15	51.00
53.00	05300	ANESTHESIOLOGY	72,980	7,506,450	0.009722	2,161	21	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,592,654	34,976,333	0.045535	48,621	2,214	54.00
57.00	05700	CT SCAN	486,743	39,180,096	0.012423	95,406	1,185	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	497,859	52,601,123	0.009465	300,871	2,848	60.00
64.00	06400	INTRAVENOUS THERAPY	292,174	5,905,727	0.049473	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	176,765	4,167,525	0.042415	43,402	1,841	65.00
66.00	06600	PHYSICAL THERAPY	422,248	6,294,402	0.067083	653,020	43,807	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,914	2,473,004	0.010883	643,874	7,007	67.00
68.00	06800	SPEECH PATHOLOGY	19,160	639,121	0.029979	185,344	5,556	68.00
69.00	06900	ELECTROCARDIOLOGY	856,445	26,804,352	0.031952	7,737	247	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	27,399	830,786	0.032980	4,560	150	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	110,704	10,292,103	0.010756	49,761	535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	97,443	27,290,596	0.003571	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	317,644	73,199,208	0.004339	1,007,462	4,371	73.00
76.97	07697	CARDIAC REHABILITATION	58,775	772,053	0.076128	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	90,348	1,151,455	0.078464	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	81,417	6,712,902	0.012128	5,911	72	90.04
91.00	09100	EMERGENCY	614,279	33,235,989	0.018482	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,231,015	0.000000	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
200.00		Total (lines 50 through 199)	7,304,037	384,662,592		3,057,740	70,164	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | 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	83,715	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	320	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	11,525	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	30,573	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	126,133	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | 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	83,715	83,715	41,714,430	0.002007	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,683,922	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	7,506,450	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	320	320	34,976,333	0.000009	54.00
57.00	05700	CT SCAN	0	0	0	39,180,096	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	52,601,123	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	5,905,727	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,167,525	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,294,402	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,473,004	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	639,121	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	11,525	11,525	26,804,352	0.000430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	830,786	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	10,292,103	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27,290,596	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73,199,208	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	772,053	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,151,455	0.000000	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0	0	0	0.000000	90.01
90.03	09002	PSYCH OUTPATIENT	0	0	0	0	0.000000	90.03
90.04	09003	WOUND CARE CLINIC	0	0	0	6,712,902	0.000000	90.04
91.00	09100	EMERGENCY	0	30,573	30,573	33,235,989	0.000920	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,231,015	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0.000000	93.00
200.00		Total (lines 50 through 199)	0	126,133	126,133	384,662,592		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | 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	0.002007	8,880	18	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	730	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,161	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000009	48,621	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	95,406	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	300,871	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	43,402	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	653,020	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	643,874	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	185,344	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000430	7,737	3	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,560	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	49,761	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,007,462	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.000000	5,911	0	0	0	90.04
91.00	09100	EMERGENCY	0.000920	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Total (lines 50 through 199)		3,057,740	21	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 12:53 pm

Title XIX | Hospital | Cost

		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	0.284490	0	1,146,211	0	0	50.00
51.00	05100	RECOVERY ROOM	0.313657	0	130,760	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.039870	0	202,813	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170872	0	1,402,702	0	0	54.00
57.00	05700	CT SCAN	0.044624	0	1,498,710	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.098808	0	1,748,112	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.520255	0	277,784	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.407007	0	38,473	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.485156	0	179,351	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285475	0	12,381	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.664991	0	3,564	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177958	0	656,986	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.313264	0	18,075	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.257578	0	223,633	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417457	0	360,129	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123636	0	1,324,077	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.891839	0	16,856	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.000755	0	25,492	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.249304	0	160,064	0	0	90.04
91.00	09100	EMERGENCY	0.270854	0	2,457,789	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.671786	0	232,108	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
200.00		Subtotal (see instructions)		0	12,116,070	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	12,116,070	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/24/2018 12:53 pm

Title XIX | Hospital | Cost

		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	326,086	0		50.00
51.00	05100	RECOVERY ROOM	41,014	0		51.00
53.00	05300	ANESTHESIOLOGY	8,086	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,682	0		54.00
57.00	05700	CT SCAN	66,878	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	172,727	0		60.00
64.00	06400	INTRAVENOUS THERAPY	144,519	0		64.00
65.00	06500	RESPIRATORY THERAPY	15,659	0		65.00
66.00	06600	PHYSICAL THERAPY	87,013	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,534	0		67.00
68.00	06800	SPEECH PATHOLOGY	2,370	0		68.00
69.00	06900	ELECTROCARDIOLOGY	116,916	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,662	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	281,236	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	150,338	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	163,704	0		73.00
76.97	07697	CARDIAC REHABILITATION	15,033	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	25,511	0		90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0	0		90.01
90.03	09002	PSYCH OUTPATIENT	0	0		90.03
90.04	09003	WOUND CARE CLINIC	39,905	0		90.04
91.00	09100	EMERGENCY	665,702	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	155,927	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
200.00		Subtotal (see instructions)	2,727,502	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	2,727,502	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/24/2018 12:53 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)		22,909	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,909	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.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		19,823	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)		7,593	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)		26,087,147	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)	5	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)	x	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)	x	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)	x	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)		26,087,147	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 minus line 36)	27	26,087,147	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,138.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,646,377	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)		8,646,377	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 12:53 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	8,055,281	7,352	1,095.66	2,816	3,085,379	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)	16,867,491	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	28,599,247	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	1,325,152	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,189,247	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,514,399	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	26,084,848	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)	3,086	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,138.73	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	3,514,121	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 12:53 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	2,638,024	26,087,147	0.101124	3,514,121	355,362	90.00
91.00	Nursing School cost	0	26,087,147	0.000000	3,514,121	0	91.00
92.00	Allied health cost	273,874	26,087,147	0.010498	3,514,121	36,891	92.00
93.00	All other Medical Education	0	26,087,147	0.000000	3,514,121	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127	Period: From 01/01/2017	Worksheet D-1
Component CCN: 14-T127	To 12/31/2017	Date/Time Prepared: 5/24/2018 12:53 pm
Title XVIII	Subprovider - IRF	PPS

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,723	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,723	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.	do	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,723	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,585	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,590,888	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)	5	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)	x	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,590,888	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 minus line 36)	27	2,590,888	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)		951.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,508,096	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)		1,508,096	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | 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)	878,094	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,386,190	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)	149,165	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	70,185	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	219,350	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,166,840	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: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | 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	245,869	2,590,888	0.094898	0	0	90.00
91.00	Nursing School cost	0	2,590,888	0.000000	0	0	91.00
92.00	Allied health cost	10,404	2,590,888	0.004016	0	0	92.00
93.00	All other Medical Education	0	2,590,888	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 12:53 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		12,149,189		30.00
31.00	03100	INTENSIVE CARE UNIT		4,788,793		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.284490	8,048,227	2,289,640	50.00
51.00	05100	RECOVERY ROOM	0.313657	666,393	209,019	51.00
53.00	05300	ANESTHESIOLOGY	0.039870	1,405,988	56,057	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170872	3,260,950	557,205	54.00
57.00	05700	CT SCAN	0.044624	4,861,624	216,945	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.098808	9,600,967	948,652	60.00
64.00	06400	INTRAVENOUS THERAPY	0.520255	669,290	348,201	64.00
65.00	06500	RESPIRATORY THERAPY	0.407007	1,536,116	625,210	65.00
66.00	06600	PHYSICAL THERAPY	0.485156	988,076	479,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285475	566,196	161,635	67.00
68.00	06800	SPEECH PATHOLOGY	0.664991	94,833	63,063	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177958	4,715,913	839,234	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.313264	104,339	32,686	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.257578	2,516,641	3,164,872	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417457	8,085,621	3,375,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123636	16,871,598	2,085,937	73.00
76.97	07697	CARDIAC REHABILITATION	0.891839	14,592	13,014	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.000755	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.249304	166,139	41,419	90.04
91.00	09100	EMERGENCY	0.270854	3,260,019	882,989	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.671786	709,962	476,943	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		68,143,484	16,867,491	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)		68,143,484		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		1,660,112		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.284490	8,880	2,526	50.00
51.00	05100	RECOVERY ROOM	0.313657	730	229	51.00
53.00	05300	ANESTHESIOLOGY	0.039870	2,161	86	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170872	48,621	8,308	54.00
57.00	05700	CT SCAN	0.044624	95,406	4,257	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.098808	300,871	29,728	60.00
64.00	06400	INTRAVENOUS THERAPY	0.520255	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.407007	43,402	17,665	65.00
66.00	06600	PHYSICAL THERAPY	0.485156	653,020	316,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285475	643,874	183,810	67.00
68.00	06800	SPEECH PATHOLOGY	0.664991	185,344	123,252	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177958	7,737	1,377	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.313264	4,560	1,428	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.257578	49,761	62,578	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417457	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123636	1,007,462	124,559	73.00
76.97	07697	CARDIAC REHABILITATION	0.891839	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.000755	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.249304	5,911	1,474	90.04
91.00	09100	EMERGENCY	0.270854	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.671786	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,057,740	878,094	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)		3,057,740		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 12:53 pm

Title XIX | Hospital | Cost

		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		2,997,263		30.00
31.00	03100	INTENSIVE CARE UNIT		738,975		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		2,182,325		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.284490	510,991	145,372	50.00
51.00	05100	RECOVERY ROOM	0.313657	45,450	14,256	51.00
53.00	05300	ANESTHESIOLOGY	0.039870	120,894	4,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170872	418,676	71,540	54.00
57.00	05700	CT SCAN	0.044624	636,693	28,412	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.098808	1,484,631	146,693	60.00
64.00	06400	INTRAVENOUS THERAPY	0.520255	96,285	50,093	64.00
65.00	06500	RESPIRATORY THERAPY	0.407007	207,429	84,425	65.00
66.00	06600	PHYSICAL THERAPY	0.485156	39,752	19,286	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285475	24,144	6,893	67.00
68.00	06800	SPEECH PATHOLOGY	0.664991	10,570	7,029	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177958	763,733	135,912	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.313264	11,945	3,742	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.257578	221,073	278,017	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417457	211,042	88,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123636	3,068,369	379,361	73.00
76.97	07697	CARDIAC REHABILITATION	0.891839	1,550	1,382	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.000755	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.249304	19,475	4,855	90.04
91.00	09100	EMERGENCY	0.270854	523,331	141,746	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.671786	72,797	48,904	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,488,830	1,660,839	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)		8,488,830		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/24/2018 12:53 pm

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		59,280		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.284490	0	0	50.00
51.00	05100	RECOVERY ROOM	0.313657	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.039870	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.170872	1,315	225	54.00
57.00	05700	CT SCAN	0.044624	2,070	92	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.098808	7,668	758	60.00
64.00	06400	INTRAVENOUS THERAPY	0.520255	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.407007	400	163	65.00
66.00	06600	PHYSICAL THERAPY	0.485156	21,016	10,196	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.285475	22,621	6,458	67.00
68.00	06800	SPEECH PATHOLOGY	0.664991	9,947	6,615	68.00
69.00	06900	ELECTROCARDIOLOGY	0.177958	165	29	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.313264	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.257578	5,979	7,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.417457	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.123636	34,013	4,205	73.00
76.97	07697	CARDIAC REHABILITATION	0.891839	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.000755	0	0	90.00
90.01	09001	BASIC DIAGNOSTIC TESTING	0.000000	0	0	90.01
90.03	09002	PSYCH OUTPATIENT	0.000000	0	0	90.03
90.04	09003	WOUND CARE CLINIC	0.249304	410	102	90.04
91.00	09100	EMERGENCY	0.270854	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.671786	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		105,604	36,362	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)		105,604		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/24/2018 12:53 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)	14,880,285	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,001,643	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)	234,685	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	6,940,939	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	196.73	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)	13.60	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.	1.03	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)	12.57	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	15.92	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)	12.57	12.00
13.00	Total allowable FTE count for the prior year.	12.57	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.	12.57	14.00
15.00	Sum of lines 12 through 14 divided by 3.	12.57	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	12.57	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.063895	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.063633	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.063633	21.00
22.00	IME payment adjustment (see instructions)	713,201	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	237,061	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)	3.35	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)	713,201	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	237,061	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.76	30.00
31.00	Percentage of Medicaid patient days (see instructions)	22.80	31.00
32.00	Sum of lines 30 and 31	27.56	32.00
33.00	Allowable disproportionate share percentage (see instructions)	11.95	33.00
34.00	Disproportionate share adjustment (see instructions)	623,848	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/24/2018 12:53 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)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000186236	0.000202098	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,113,223	1,367,537	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	832,630	344,695	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,177,325		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)	23,630,987		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)	23,868,048	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,895,076	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).	426,056	52.00
53.00	Nursing and Allied Health Managed Care payment	157,146	53.00
54.00	Special add-on payments for new technologies	7,321	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).	116,193	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	26,216	58.00
59.00	Total (sum of amounts on lines 49 through 58)	26,496,056	59.00
60.00	Primary payer payments	8,888	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	26,487,168	61.00
62.00	Deductibles billed to program beneficiaries	2,561,284	62.00
63.00	Coinsurance billed to program beneficiaries	41,454	63.00
64.00	Allowable bad debts (see instructions)	497,578	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	323,426	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	330,747	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	24,207,856	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 PER PS&R	-34	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)	130,873	70.93
70.94	HRR adjustment amount (see instructions)	-20,322	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/24/2018 12:53 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)		24,318,373	71.00
71.01	Sequestration adjustment (see instructions)		486,367	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		23,688,621	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)		143,385	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		173,658	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: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/24/2018 12:53 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	8,275	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,130,611	2.00
3.00	OPPS payments	9,703,410	3.00
4.00	Outlier payment (see instructions)	28,152	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.757	5.00
6.00	Line 2 times line 5	9,182,873	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	25,029	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	8,275	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	66,966	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)	66,966	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)	66,966	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	58,691	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)	8,275	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	9,756,591	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,732,693	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	8,032,173	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	167,303	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)	8,199,476	30.00
31.00	Primary payer payments	75	31.00
32.00	Subtotal (line 30 minus line 31)	8,199,401	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)	325,113	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	211,323	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	230,175	36.00
37.00	Subtotal (see instructions)	8,410,724	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS PER PS&R	440	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)	8,411,164	40.00
40.01	Sequestration adjustment (see instructions)	168,223	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	8,245,798	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2,857	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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2018 12:53 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		23,606,393		8,211,542	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	08/17/2017	82,228	08/17/2017	34,256	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)		82,228		34,256	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)		23,688,621		8,245,798	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		143,385		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2,857	6.02
7.00	Total Medicare program liability (see instructions)		23,832,006		8,242,941	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: 14-0127 | Component CCN: 14-T127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Subprovider - IRF | 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		2,297,859		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/17/2017	13,797		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)		13,797		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)		2,311,656		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,355		0	6.02
7.00	Total Medicare program liability (see instructions)		2,290,301		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/24/2018 12:53 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: 14-0127 Component CCN: 14-T127	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/24/2018 12:53 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	2,220,615	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0221	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	53,073	3.00
4.00	Outlier Payments	86,480	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	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	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	7.460274	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	2,360,168	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	2,360,168	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	2,360,168	19.00
20.00	Deductibles	31,584	20.00
21.00	Subtotal (line 19 minus line 20)	2,328,584	21.00
22.00	Coinsurance	329	22.00
23.00	Subtotal (line 21 minus line 22)	2,328,255	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,170	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,711	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,189	26.00
27.00	Subtotal (sum of lines 23 and 25)	2,330,966	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	6,076	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	2,337,042	32.00
32.01	Sequestration adjustment (see instructions)	46,741	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	2,311,656	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-21,355	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	86,480	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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-4 | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			13.60	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.03	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			12.57	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			15.92	6.00
7.00	Enter the lesser of line 5 or line 6			12.57	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	6.57	8.41	14.98	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	5.19	6.64	11.83	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	5.19	6.64		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	4.96	7.61		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	5.23	7.34		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	5.13	7.20		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	5.13	7.20		17.00
18.00	Per resident amount	99,664.27	99,664.27		18.00
19.00	Approved amount for resident costs	511,278	717,583	1,228,861	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			3.35	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,228,861	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	11,994	3,063		26.00
27.00	Total Inpatient Days (see instructions)	30,287	30,287		27.00
28.00	Ratio of inpatient days to total inpatient days	0.396011	0.101132		28.00
29.00	Program direct GME amount	486,642	124,277		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		17,560		30.00
31.00	Net Program direct GME amount			593,359	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-4 | Date/Time Prepared: 5/24/2018 12:53 pm

Title XVIII | Hospital | PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	30,985,437	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	8,888	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	30,976,549	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	12,163,915	42.00
43.00	Primary payer payments (see instructions)	75	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	12,163,840	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	43,140,389	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.718041	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.281959	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	593,359	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	426,056	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	167,303	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/24/2018 12:53 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	229,643,000	0	0	0	1.00
2.00	Temporary investments	82,664,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	672,820,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	191,459,000	0	0	0	9.00
10.00	Due from other funds	23,729,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	1,200,315,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	158,161,000	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	2,982,049,000	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	1,494,843,000	0	0	0	23.00
24.00	Accumulated depreciation	-2,508,470,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,126,583,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	4,829,122,000	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	444,752,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,273,874,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,600,772,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	346,603,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	386,896,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	88,828,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	421,544,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,243,871,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	1,493,648,000	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	848,770,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	2,342,418,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	3,586,289,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,014,483,000				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)	5,014,483,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,600,772,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/24/2018 12:53 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		4,173,106,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		18,213,952				2.00
3.00	Total (sum of line 1 and line 2)		4,191,319,952		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ADJ TO AHC FUND BALANCE	823,163,049		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)		823,163,049		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,014,483,001		0		11.00
12.00	RECONCILING ITEM	0		1		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		1		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,014,483,001		-1		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	ADJ TO AHC FUND BALANCE		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	RECONCILING ITEM		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: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2018 12:53 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	49,752,719		49,752,719	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	2,853,680		2,853,680	3.00
4.00	SUBPROVIDER	0		0	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)	52,606,399		52,606,399	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	11,080,538		11,080,538	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)	11,080,538		11,080,538	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	63,686,937		63,686,937	17.00
18.00	Ancillary services	159,229,256	190,251,172	349,480,428	18.00
19.00	Outpatient services	9,152,356	37,179,005	46,331,361	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	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)	232,068,549	227,430,177	459,498,726	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		166,970,865		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		166,970,865		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0127 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-3 | Date/Time Prepared: 5/24/2018 12:53 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	459,498,726	1.00
2.00	Less contractual allowances and discounts on patients' accounts	278,688,190	2.00
3.00	Net patient revenues (line 1 minus line 2)	180,810,536	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	166,970,865	4.00
5.00	Net income from service to patients (line 3 minus line 4)	13,839,671	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	998,612	6.00
7.00	Income from investments	10,198	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	205,949	13.00
14.00	Revenue from meals sold to employees and guests	225,860	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	1,244,707	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	158,265	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	1,007,864	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	522,826	24.00
25.00	Total other income (sum of lines 6-24)	4,374,281	25.00
26.00	Total (line 5 plus line 25)	18,213,952	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)	18,213,952	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0127	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/24/2018 12:53 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,683,538	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	35,440	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)	76.96	3.00
4.00	Number of interns & residents (see instructions)	12.57	4.00
5.00	Indirect medical education percentage (see instructions)	4.72	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)	79,463	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	4.76	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	22.80	8.00
9.00	Sum of lines 7 and 8	27.56	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.74	10.00
11.00	Disproportionate share adjustment (see instructions)	96,635	11.00
12.00	Total prospective capital payments (see instructions)	1,895,076	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