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: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet S Parts I-III Date/Time Prepared: 1/30/2018 10:45 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/30/2018 Time: 10:45 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORTHWESTERN LAKE FOREST HOSPITAL (14-0130) for the cost reporting period beginning 09/01/2016 and ending 08/31/2017 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.

(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	391,421	416,763	15,680	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	391,421	416,763	15,680	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: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/30/2018 10:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 660 WESTMORELAND ROAD	PO Box:			1.00
2.00	City: LAKE FOREST	State: IL	Zip Code: 60045	County: LAKE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	NORTHWESTERN LAKE FOREST HOSPITAL	140130	29404	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	NORTHWESTERN LAKE FOREST HOSPITAL	145216	29404		07/01/1970	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	NORTHWESTERN LAKE FOREST HOME HEALTH	147045	29404		07/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2016	08/31/2017	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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.	693	552	0	0	1,842	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/30/2018 10:32 am

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	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 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
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 1/30/2018 10:32 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/30/2018 10:32 am

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	604,100	58,910	2,754,157	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 state health or similar taxes? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 1/30/2018 10:32 am

		1.00	2.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0640	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: NORTHWESTERN MEMORIAL HEALTHCARE AND	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 251 E HURON ST	PO Box:		142.00
143.00	City: CHICAGO	State: IL	Zip Code: 60611	143.00

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

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

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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.01	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part I Date/Time Prepared: 1/30/2018 10:32 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	09/01/2015	08/31/2016	170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 1/30/2018 10:32 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	11/30/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/01/2017	Y	12/01/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 1/30/2018 10:32 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions					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?					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.					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.					38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.					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.	JOHN		VANDER LAAN		41.00
42.00	Enter the employer/company name of the cost report preparer.	NORTHWESTERN MEMORIAL HEALTHCARE				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(312) 926-6618		JVANDERL@NMH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet S-2 Part II Date/Time Prepared: 1/30/2018 10:32 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 1/30/2018 10:32 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	107	38,435	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)		107	38,435	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,588	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)		117	42,023	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	0	10,220		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	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						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		117				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)		8	2,885			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/30/2018 10:32 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,627	901	20,214			1.00
2.00	HMO and other (see instructions)	963	1,842				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	8,627	901	20,214			7.00
8.00	INTENSIVE CARE UNIT	1,381	117	2,620			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		163	3,658			13.00
14.00	Total (see instructions)	10,008	1,181	26,492	17.03	1,165.30	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	6,648	0	7,932	0.00	28.90	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	9,641	0.00	35.20	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				17.03	1,229.40	27.00
28.00	Observation Bed Days		0	4,345			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			346			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	64	718			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			212			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 1/30/2018 10:32 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,563	415	7,298	1.00
2.00	HMO and other (see instructions)			221	513		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,563	415	7,298	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					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						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 1/30/2018 10:32 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	91,065,278	0	91,065,278	2,540,000.00	35.85	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	992,892	0	992,892	35,438.00	28.02	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	2,059,680	0	2,059,680	59,555.00	34.58	9.00
10.00	Excluded area salaries (see instructions)		5,465,931	20,986	5,486,917	151,684.00	36.17	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		764,800	0	764,800	10,341.00	73.96	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		1,192,351	0	1,192,351	12,185.00	97.85	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		33,525,606	0	33,525,606	637,166.00	52.62	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		22,022,788	0	22,022,788			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,132,566	0	2,132,566			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		206,128	0	206,128			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	84,417	0	84,417	4,464.00	18.91	26.00
27.00	Administrative & General	5.00	12,100,189	0	12,100,189	178,362.00	67.84	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 1/30/2018 10:32 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,672,841	0	3,672,841	127,993.00	28.70	30.00
31.00	Laundry & Linen Service	8.00	302,139	0	302,139	19,847.00	15.22	31.00
32.00	Housekeeping	9.00	1,651,221	-20,986	1,630,235	105,945.00	15.39	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	10,372	0	10,372	186.00	55.76	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	29,745	0	29,745	1,182.00	25.16	37.00
38.00	Nursing Administration	13.00	5,142,298	0	5,142,298	107,974.00	47.63	38.00
39.00	Central Services and Supply	14.00	849,188	0	849,188	40,397.00	21.02	39.00
40.00	Pharmacy	15.00	2,627,828	0	2,627,828	57,788.00	45.47	40.00
41.00	Medical Records & Medical Records Library	16.00	675,813	0	675,813	25,297.00	26.72	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 1/30/2018 10:32 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		90,072,386	0	90,072,386	2,504,562.00	35.96	1.00
2.00	Excluded area salaries (see instructions)		7,525,611	20,986	7,546,597	211,239.00	35.73	2.00
3.00	Subtotal salaries (line 1 minus line 2)		82,546,775	-20,986	82,525,789	2,293,323.00	35.99	3.00
4.00	Subtotal other wages & related costs (see inst.)		35,482,757	0	35,482,757	659,692.00	53.79	4.00
5.00	Subtotal wage-related costs (see inst.)		22,022,788	0	22,022,788	0.00	26.69	5.00
6.00	Total (sum of lines 3 thru 5)		140,052,320	-20,986	140,031,334	2,953,015.00	47.42	6.00
7.00	Total overhead cost (see instructions)		27,146,051	-20,986	27,125,065	669,435.00	40.52	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 1/30/2018 10:32 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	6,327,976	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6,838,726	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	2,513,533	9.00
10.00	Dental, Hearing and Vision Plan	396,255	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	151,114	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)	224,992	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,011,419	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	6,502,629	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-79,090	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	202,590	22.00
23.00	Tuition Reimbursement	271,340	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	24,361,484	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 1/30/2018 10:32 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	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			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0130 | Component CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-4 | Date/Time Prepared: 1/30/2018 10:32 am

Home Health Agency I | PPS

					1.00		
0.00	County				LAKE		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	0.00	0.00	0.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	8.16	0.00	8.16	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			16.82	0.00	16.82	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			6.38	0.00	6.38	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.61	0.00	1.61	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.50	0.00	0.50	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.99	0.00	1.99	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
20.01				29404			20.01
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,545	195	96	0	4,836	21.00
22.00	Skilled Nursing Visit Charges	0	0	0	0	0	22.00
23.00	Physical Therapy Visits	3,142	32	101	0	3,275	23.00
24.00	Physical Therapy Visit Charges	0	0	0	0	0	24.00
25.00	Occupational Therapy Visits	749	3	28	0	780	25.00
26.00	Occupational Therapy Visit Charges	0	0	0	0	0	26.00
27.00	Speech Pathology Visits	0	0	0	0	0	27.00
28.00	Speech Pathology Visit Charges	0	0	0	0	0	28.00
29.00	Medical Social Service Visits	148	2	3	0	153	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	569	2	26	0	597	31.00
32.00	Home Health Aide Visit Charges	0	0	0	0	0	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	9,153	234	254	0	9,641	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	0	0	0	0	0	35.00
36.00	Total Number of Episodes (standard/non outlier)	0		0	0	0	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-5 | Date/Time Prepared: 1/30/2018 10:32 am

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

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

		Prior to 1/1	After 12/31	
		1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	4	10.03
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list	0		11.00
12.00	Number of patients transplanted during the cost reporting period	0		12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

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

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

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-5 | Date/Time Prepared: 1/30/2018 10:32 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-7 | Date/Time Prepared: 1/30/2018 10:32 am

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	533	0	533	12.00
13.00		RUB	900	0	900	13.00
14.00		RUA	408	0	408	14.00
15.00		RVC	1,203	0	1,203	15.00
16.00		RVB	1,547	0	1,547	16.00
17.00		RVA	692	0	692	17.00
18.00		RHC	275	0	275	18.00
19.00		RHB	271	0	271	19.00
20.00		RHA	192	0	192	20.00
21.00		RMC	46	0	46	21.00
22.00		RMB	98	0	98	22.00
23.00		RMA	35	0	35	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	29	0	29	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	1	0	1	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	19	0	19	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	35	0	35	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	15	0	15	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	56	0	56	41.00
42.00		LC1	20	0	20	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	2	0	2	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	36	0	36	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	47	0	47	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	17	0	17	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	40	0	40	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-7 | Date/Time Prepared: 1/30/2018 10:32 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	32	0	32	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	62	0	62	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	1	0	1	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	29	0	29	78.00
199.00		AAA	7	0	7	199.00
200.00	TOTAL		6,648	0	6,648	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	29404		201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00	Y	205.00
206.00	OTHER (STAFF MEETINGS)	0	0.00	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	9,970,908			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet S-10 | Date/Time Prepared: 1/30/2018 10:32 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.249235	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,461,799	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	125,851,719	6.00
7.00	Medicaid cost (line 1 times line 6)	31,366,653	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)	26,904,854	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)	26,904,854	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)	36,595,615	996,789	37,592,404	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	9,120,908	996,789	10,117,697	21.00
22.00	Payments received from patients for amounts previously written off as charity care	9,740,069	116,935	9,857,004	22.00
23.00	Cost of charity care (line 21 minus line 22)	0	879,854	879,854	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	18,387,217	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	275,821	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	424,340	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	17,962,877	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	4,625,497	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,505,351	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	32,410,205	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		13,508,246	13,508,246	0	13,508,246	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		6,104,835	6,104,835	0	6,104,835	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	84,417	-2,892,144	-2,807,727	0	-2,807,727	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,100,189	85,867,253	97,967,442	0	97,967,442	5.00
7.00	00700	OPERATION OF PLANT	3,672,841	11,322,738	14,995,579	0	14,995,579	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	302,139	328,333	630,472	0	630,472	8.00
9.00	00900	HOUSEKEEPING	1,651,221	2,126,035	3,777,256	-20,986	3,756,270	9.00
10.00	01000	DIETARY	10,372	4,941,755	4,952,127	-2,870,831	2,081,296	10.00
11.00	01100	CAFETERIA	0	736,398	736,398	2,392,747	3,129,145	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	29,745	77,664	107,409	0	107,409	12.00
13.00	01300	NURSING ADMINISTRATION	5,142,298	2,367,446	7,509,744	0	7,509,744	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	849,188	1,266,965	2,116,153	0	2,116,153	14.00
15.00	01500	PHARMACY	2,627,828	28,879,234	31,507,062	-36,410,905	-4,903,843	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	675,813	357,771	1,033,584	0	1,033,584	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	992,892	179,482	1,172,374	0	1,172,374	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	86,763	426,000	512,763	0	512,763	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,249,688	4,333,691	15,583,379	-811,983	14,771,396	30.00
31.00	03100	INTENSIVE CARE UNIT	2,273,791	1,297,392	3,571,183	-20,941	3,550,242	31.00
43.00	04300	NURSERY	814,803	231,773	1,046,576	767,789	1,814,365	43.00
44.00	04400	SKILLED NURSING FACILITY	2,059,680	1,005,564	3,065,244	0	3,065,244	44.00
45.00	04500	NURSING FACILITY	1,869,285	1,184,110	3,053,395	499,070	3,552,465	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,227,508	17,500,446	25,727,954	-11,337,784	14,390,170	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,221,135	1,116,141	3,337,276	-26,438	3,310,838	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,732,500	4,905,884	11,638,384	-350,045	11,288,339	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	975,970	921,080	1,897,050	0	1,897,050	55.00
57.00	05700	CT SCAN	740,303	388,163	1,128,466	-176,639	951,827	57.00
58.00	05800	MRI	1,939,836	814,263	2,754,099	-118,176	2,635,923	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,290,232	2,098,843	3,389,075	-1,900,903	1,488,172	59.00
60.00	06000	LABORATORY	3,368,467	5,762,903	9,131,370	-10,525	9,120,845	60.00
65.00	06500	RESPIRATORY THERAPY	1,083,245	481,740	1,564,985	-36,444	1,528,541	65.00
66.00	06600	PHYSICAL THERAPY	3,416,330	863,216	4,279,546	-5	4,279,541	66.00
68.00	06800	SPEECH PATHOLOGY	905,942	523,732	1,429,674	0	1,429,674	68.00
69.00	06900	ELECTROCARDIOLOGY	754,379	263,675	1,018,054	0	1,018,054	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	216,181	126,816	342,997	0	342,997	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-522,132	-522,132	7,732,331	7,210,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,244,908	6,244,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	37,190,563	37,190,563	73.00
76.97	07697	CARDIAC REHABILITATION	608,951	188,841	797,792	0	797,792	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,345,350	570,728	1,916,078	-80,266	1,835,812	90.01
90.02	09002	WOUND CLINIC	448,929	871,524	1,320,453	-9,233	1,311,220	90.02
91.00	09100	EMERGENCY	5,288,023	2,367,527	7,655,550	-645,304	7,010,246	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,412,398	550,879	1,963,277	0	1,963,277	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,919,812	1,400,560	4,320,372	0	4,320,372	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	90,388,444	204,845,370	295,233,814	0	295,233,814	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	138,444	71,560	210,004	0	210,004	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	211,454	2,818,484	3,029,938	0	3,029,938	192.00
194.00	07950	HEALTH & FITNESS CENTER	326,936	760,353	1,087,289	0	1,087,289	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	105	105	0	105	194.01
200.00		TOTAL (SUM OF LINES 118-199)	91,065,278	208,495,872	299,561,150	0	299,561,150	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-4,097,789	9,410,457		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-128,359	5,976,476		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-37,046	-2,844,773		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,737,392	120,704,834		5.00
7.00	00700	OPERATION OF PLANT	-33,381	14,962,198		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	630,472		8.00
9.00	00900	HOUSEKEEPING	0	3,756,270		9.00
10.00	01000	DIETARY	-1,009,039	1,072,257		10.00
11.00	01100	CAFETERIA	-775,811	2,353,334		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	-64,848	42,561		12.00
13.00	01300	NURSING ADMINISTRATION	-160,020	7,349,724		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,116,153		14.00
15.00	01500	PHARMACY	-59,232	-4,963,075		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,033,584		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,172,374		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	512,763		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-4,631	14,766,765		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,550,242		31.00
43.00	04300	NURSERY	0	1,814,365		43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,065,244		44.00
45.00	04500	NURSING FACILITY	0	3,552,465		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-25	14,390,145		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-3,237	3,307,601		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,081	11,286,258		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,897,050		55.00
57.00	05700	CT SCAN	0	951,827		57.00
58.00	05800	MRI	0	2,635,923		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,488,172		59.00
60.00	06000	LABORATORY	-60	9,120,785		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,528,541		65.00
66.00	06600	PHYSICAL THERAPY	-3,405	4,276,136		66.00
68.00	06800	SPEECH PATHOLOGY	-1,069	1,428,605		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,018,054		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	342,997		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,210,199		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,244,908		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,190,563		73.00
76.97	07697	CARDIAC REHABILITATION	-3,353	794,439		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0	1,835,812		90.01
90.02	09002	WOUND CLINIC	0	1,311,220		90.02
91.00	09100	EMERGENCY	0	7,010,246		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	1,963,277		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	-1,973,234	2,347,138		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,380,772	309,614,586		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-127,162	82,842		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-6,598,449	-3,568,511		192.00
194.00	07950	HEALTH & FITNESS CENTER	-1,029,000	58,289		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	105		194.01
200.00		TOTAL (SUM OF LINES 118-199)	6,626,161	306,187,311		200.00

RECLASSIFICATIONS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6 | Date/Time Prepared: 1/30/2018 10:32 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,244,908		1.00
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
	TOTALS		0	6,244,908		
	B - MED SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,732,331		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
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
	TOTALS		0	7,732,331		
	C - DRUG RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	37,190,563		1.00
2.00		0.00	0	0		2.00
4.00		0.00	0	0		4.00
6.00		0.00	0	0		6.00
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
	TOTALS		0	37,190,563		
	D - HOUSEKEEPING					
1.00	NURSING FACILITY	45.00	20,986	0		1.00
	TOTALS		20,986	0		
	H - NURSERY RECLASS					
1.00	NURSERY	43.00	571,308	196,481		1.00
	TOTALS		571,308	196,481		
	J - DIETARY RECLASS					
1.00	CAFETERIA	11.00	0	2,392,747		1.00
2.00	NURSING FACILITY	45.00	0	478,084		2.00
	TOTALS		0	2,870,831		
500.00	Grand Total: Increases		592,294	54,235,114		500.00

RECLASSIFICATIONS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-6 | Date/Time Prepared: 1/30/2018 10:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - IMPLANT RECLASS						
1.00		0.00	0	0	0		1.00
6.00	OPERATING ROOM	50.00	0	5,545,456	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	65,022	0		7.00
8.00	CARDIAC CATHETERIZATION	59.00	0	632,994	0		8.00
9.00	WOUND CLINIC	90.02	0	1,436	0		9.00
	TOTALS		0	6,244,908			
	B - MED SUPPLY						
1.00		0.00	0	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	44,194	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	20,941	0		3.00
5.00	OPERATING ROOM	50.00	0	5,735,004	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	26,438	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	206,407	0		7.00
8.00	CT SCAN	57.00	0	33	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	1,235,926	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	36,444	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	5	0		11.00
12.00	OP PEDS ONC CLINIC	90.01	0	374	0		12.00
13.00	EMERGENCY	91.00	0	426,565	0		13.00
	TOTALS		0	7,732,331			
	C - DRUG RECLASS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	36,410,905	0		2.00
4.00	OPERATING ROOM	50.00	0	57,324	0		4.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	78,616	0		6.00
8.00	CT SCAN	57.00	0	176,606	0		8.00
9.00	MRI	58.00	0	118,176	0		9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	31,983	0		10.00
11.00	LABORATORY	60.00	0	10,525	0		11.00
12.00	OP PEDS ONC CLINIC	90.01	0	79,892	0		12.00
13.00	WOUND CLINIC	90.02	0	7,797	0		13.00
14.00	EMERGENCY	91.00	0	218,739	0		14.00
	TOTALS		0	37,190,563			
	D - HOUSEKEEPING						
1.00	HOUSEKEEPING	9.00	20,986	0	0		1.00
	TOTALS		20,986	0			
	H - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	571,308	196,481	0		1.00
	TOTALS		571,308	196,481			
	J - DIETARY RECLASS						
1.00	DIETARY	10.00	0	2,870,831	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	2,870,831			
500.00	Grand Total: Decreases		592,294	54,235,114			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 1/30/2018 10:32 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	52,023,598	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	173,911,546	13,149,834	0	13,149,834	2,440,212	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	49,437,689	11,800,343	0	11,800,343	989,609	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	275,372,833	24,950,177	0	24,950,177	3,429,821	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	275,372,833	24,950,177	0	24,950,177	3,429,821	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	52,023,598	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	184,621,168	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	60,248,423	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	296,893,189	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	296,893,189	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 1/30/2018 10:32 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	13,508,246	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,104,835	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	19,613,081	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	13,508,246	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,104,835	2.00
3.00	Total (sum of lines 1-2)	0	19,613,081	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 1/30/2018 10:32 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	184,621,168	0	184,621,168	0.753957	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	60,248,423	-6	60,248,429	0.246043	0	2.00
3.00	Total (sum of lines 1-2)	244,869,591	-6	244,869,597	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	9,410,457	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,976,476	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,386,933	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	9,410,457	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,976,476	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	15,386,933	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/30/2018 10:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	0			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	31,356,995			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	6,139	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	FOOD INCOME & MISC ADJ	B	-709,843	DIETARY	10.00	0	33.00
33.03	FOOD INCOME & MISC ADJ	B	-775,811	CAFETERIA	11.00	0	33.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8 | Date/Time Prepared: 1/30/2018 10:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	OTHER INCOME	B	-454,162	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	OTHER INCOME	B	-1,335	OPERATION OF PLANT	7.00	0	34.01
34.02	OTHER INCOME	B	-299,196	DIETARY	10.00	0	34.02
34.03	OTHER INCOME	B	-1,378	MAINTENANCE OF PERSONNEL	12.00	0	34.03
34.04	OTHER INCOME	B	-160,020	NURSING ADMINISTRATION	13.00	0	34.04
34.05	OTHER INCOME	B	-59,232	PHARMACY	15.00	0	34.05
34.06	OTHER INCOME	B	-4,631	ADULTS & PEDIATRICS	30.00	0	34.06
34.07	OTHER INCOME	B	-25	OPERATING ROOM	50.00	0	34.07
34.08	OTHER INCOME	B	-3,237	DELIVERY ROOM & LABOR ROOM	52.00	0	34.08
34.09	OTHER INCOME	B	-2,081	RADIOLOGY-DIAGNOSTIC	54.00	0	34.09
34.10	OTHER INCOME	B	-3,405	PHYSICAL THERAPY	66.00	0	34.10
34.11	OTHER INCOME	B	-1,069	SPEECH PATHOLOGY	68.00	0	34.11
34.12	OTHER INCOME	B	-3,353	CARDIAC REHABILITATION	76.97	0	34.12
34.13	OTHER INCOME	B	-60	LABORATORY	60.00	0	34.13
34.14	OTHER INCOME	B	-127,162	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	34.14
34.16	OTHER INCOME	B	-1,973,234	HOME HEALTH AGENCY	101.00	0	34.16
36.03	RENTAL INCOME	B	-32,046	OPERATION OF PLANT	7.00	0	36.03
36.04	RENTAL INCOME	B	-5,566,571	PHYSICIANS' PRIVATE OFFICES	192.00	0	36.04
36.05	RENTAL INCOME CAPPED AT EXPENSE	A	-52,030	MAINTENANCE OF PERSONNEL	12.00	0	36.05
38.00	HAP EXCLUDED	A	-3,291,246	ADMINISTRATIVE & GENERAL	5.00	0	38.00
38.01	IHA LOBBYING PORTION OF DUES	A	-32,283	ADMINISTRATIVE & GENERAL	5.00	0	38.01
38.02	AHA LOBBING PORITON OF DUES	A	-8,177	ADMINISTRATIVE & GENERAL	5.00	0	38.02
38.03	PHYSICIAN AND HOSPITALIST EXPENSE	A	-4,833,735	ADMINISTRATIVE & GENERAL	5.00	0	38.03
39.00	REAL ESTATE TAX	A	-37,046	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
39.01	REAL ESTATE TAX	A	-11,440	MAINTENANCE OF PERSONNEL	12.00	0	39.01
39.02	REAL ESTATE TAX	A	-1,031,878	PHYSICIANS' PRIVATE OFFICES	192.00	0	39.02
40.01	OTHER INCOME	A	-1,029,000	HEALTH & FITNESS CENTER	194.00	0	40.01
43.00	CAPITAL BUILDING TO MEDICARE BA	A	-4,097,789	CAP REL COSTS-BLDG & FIXT	1.00	9	43.00
43.01	CAPITAL EQUIPMENT TO MEDICARE BA	A	-134,498	CAP REL COSTS-MVBLE EQUIP	2.00	9	43.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		6,626,161				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: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 1/30/2018 10:32 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	0.00			0	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	VARIOUS HFI	105,584	105,584	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	VARIOUS HFI	202,383	202,383	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	VARIOUS NMHC	56,552,123	25,195,128	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	VARIOUS NMH	1,222,990	1,222,990	3.02
3.03	5.00	ADMINISTRATIVE & GENERAL	VARIOUS NM700	2,700,697	2,700,697	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	VARIOUS NMG	20,304,293	20,304,293	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	VARIOUS WRJ980	20,409	20,409	3.05
3.06	10.00	DIETARY	VARIOUS HFI	1,500	1,500	3.06
3.07	13.00	NURSING ADMINISTRATION	VARIOUS HFI	1,738	1,738	3.07
3.08	22.00	I&R SERVICES-OTHER PRGM COST	VARIOUS NMG	231,479	231,479	3.08
3.09	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS NMG	423,063	423,063	3.09
3.10	55.00	RADIOLOGY-THERAPEUTIC	VARIOUS NMG	230,000	230,000	3.10
3.11	192.00	PHYSICIANS' PRIVATE OFFICES	VARIOUS NMH	33	33	3.11
3.12	192.00	PHYSICIANS' PRIVATE OFFICES	VARIOUS NMG	608,933	608,933	3.12
3.13	101.00	HOME HEALTH AGENCY	VARIOUS WR935	84,812	84,812	3.13
3.14	0.00			0	0	3.14
3.15	0.00			0	0	3.15
3.16	0.00			0	0	3.16
3.17	0.00			0	0	3.17
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			82,690,037	51,333,042	5.00

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

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

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

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

6.00	B		0.00	NM HEALTHCARE	100.00	6.00
7.00	B		0.00	NM HOSPITAL	100.00	7.00
8.00	B		0.00	NM FOUNDATION	100.00	8.00
9.00	B		0.00	NM MEDICAL GROUP	100.00	9.00
9.01	B		0.00	LF HEALTH AND FITNESS INSTITUTE	100.00	9.01
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 1/30/2018 10:32 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	31,356,995	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
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
3.13	0	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
3.17	0	0		3.17
4.00	0	0		4.00
5.00	31,356,995			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	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00	HEALTHCARE		9.00
9.01	HEALTHCARE		9.01
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.

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,410,457	9,410,457				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,976,476		5,976,476			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,844,773	92,365	0	-2,752,408		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	120,704,834	659,701	173,723	0	121,538,258	5.00
7.00	00700	OPERATION OF PLANT	14,962,198	2,035,781	184,020	0	17,181,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	630,472	26,280	12,983	0	669,735	8.00
9.00	00900	HOUSEKEEPING	3,756,270	100,463	4,291	0	3,861,024	9.00
10.00	01000	DIETARY	1,072,257	71,455	1,252	0	1,144,964	10.00
11.00	01100	CAFETERIA	2,353,334	19,967	1,724	0	2,375,025	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	42,561	96,569	0	0	139,130	12.00
13.00	01300	NURSING ADMINISTRATION	7,349,724	17,896	5,661	0	7,373,281	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,116,153	160,430	92,853	0	2,369,436	14.00
15.00	01500	PHARMACY	-4,963,075	33,792	98,952	0	-4,830,331	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,033,584	39,357	0	0	1,072,941	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,172,374	0	0	0	1,172,374	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	512,763	0	31,021	0	543,784	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,766,765	254,172	45,111	0	15,066,048	30.00
31.00	03100	INTENSIVE CARE UNIT	3,550,242	45,693	26,043	0	3,621,978	31.00
43.00	04300	NURSERY	1,814,365	5,409	18,549	0	1,838,323	43.00
44.00	04400	SKILLED NURSING FACILITY	3,065,244	152,288	8,537	0	3,226,069	44.00
45.00	04500	NURSING FACILITY	3,552,465	254,867	2,190	0	3,809,522	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,390,145	754,920	1,790,522	0	16,935,587	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,307,601	84,397	76,218	0	3,468,216	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,286,258	234,142	1,717,971	0	13,238,371	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,897,050	145,318	599,089	0	2,641,457	55.00
57.00	05700	CT SCAN	951,827	10,867	31,594	0	994,288	57.00
58.00	05800	MRI	2,635,923	210,372	450,474	0	3,296,769	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,488,172	31,989	72,531	0	1,592,692	59.00
60.00	06000	LABORATORY	9,120,785	143,046	206,888	0	9,470,719	60.00
65.00	06500	RESPIRATORY THERAPY	1,528,541	2,064	32,538	0	1,563,143	65.00
66.00	06600	PHYSICAL THERAPY	4,276,136	191,138	7,909	0	4,475,183	66.00
68.00	06800	SPEECH PATHOLOGY	1,428,605	182,179	13,727	0	1,624,511	68.00
69.00	06900	ELECTROCARDIOLOGY	1,018,054	64,158	91,059	0	1,173,271	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	342,997	33,981	29,886	0	406,864	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,210,199	0	0	0	7,210,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,244,908	0	0	0	6,244,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,190,563	0	0	0	37,190,563	73.00
76.97	07697	CARDIAC REHABILITATION	794,439	9,244	8,702	0	812,385	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,835,812	95,430	3,586	0	1,934,828	90.01
90.02	09002	WOUND CLINIC	1,311,220	13,377	8,327	0	1,332,924	90.02
91.00	09100	EMERGENCY	7,010,246	228,284	109,231	0	7,347,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,963,277	49,176	12,365	0	2,024,818	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	2,347,138	501	6,394	0	2,354,033	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	309,614,586	6,551,068	5,975,921	0	309,507,050	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	82,842	8,918	555	0	92,315	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-3,568,511	2,831,021	0	0	-737,490	192.00
194.00	07950	HEALTH & FITNESS CENTER	58,289	0	0	0	58,289	194.00
194.01	07951	OCCUPATIONAL HEALTH	105	19,450	0	0	19,555	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	-2,752,408	-2,752,408	201.00
202.00		TOTAL (sum lines 118-201)	306,187,311	9,410,457	5,976,476	-2,752,408	306,187,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	121,538,258					5.00
7.00	00700	OPERATION OF PLANT	10,821,773	28,003,772				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	421,821	0	1,091,556			8.00
9.00	00900	HOUSEKEEPING	2,431,796	486,001	545,778	7,324,599		9.00
10.00	01000	DIETARY	721,135	238,996	0	111,656	2,216,751	10.00
11.00	01100	CAFETERIA	1,495,867	845,478	0	29,776	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	87,629	100,671	0	14,887	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,643,928	1,142,572	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,492,347	211,738	0	74,436	0	14.00
15.00	01500	PHARMACY	0	753,730	0	44,662	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	675,773	217,850	0	163,761	0	16.00
17.00	01700	SOCIAL SERVICE	0	465,698	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	738,399	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	342,493	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,489,079	3,007,331	298,503	4,183,358	1,160,988	30.00
31.00	03100	INTENSIVE CARE UNIT	2,281,238	540,656	33,046	334,967	159,225	31.00
43.00	04300	NURSERY	1,157,835	63,999	75,752	104,212	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,031,881	1,801,884	8,038	238,198	546,674	44.00
45.00	04500	NURSING FACILITY	2,399,359	3,015,551	48,713	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,666,575	4,338,039	18,648	774,144	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,184,393	998,557	22,510	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,337,950	1,652,529	0	178,648	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,663,674	683,689	0	0	0	55.00
57.00	05700	CT SCAN	626,234	128,560	0	0	0	57.00
58.00	05800	MRI	2,076,411	563,840	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,003,128	378,516	0	0	0	59.00
60.00	06000	LABORATORY	5,964,962	1,070,002	0	223,311	0	60.00
65.00	06500	RESPIRATORY THERAPY	984,517	24,448	0	66,994	0	65.00
66.00	06600	PHYSICAL THERAPY	2,818,613	1,509,075	4,626	81,881	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,023,169	655,377	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	738,964	199,936	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	256,256	402,050	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,541,214	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,933,243	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,423,835	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	511,666	109,382	2,247	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	1,218,617	454,809	0	349,854	0	90.01
90.02	09002	WOUND CLINIC	839,518	158,277	33,695	0	0	90.02
91.00	09100	EMERGENCY	4,627,855	1,605,741	0	290,305	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	1,275,295	172,889	0	0	349,864	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,482,645	5,901	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	121,431,087	28,003,772	1,091,556	7,265,050	2,216,751	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	58,143	0	0	59,549	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	36,712	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	12,316	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	121,538,258	28,003,772	1,091,556	7,324,599	2,216,751	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	4,746,146					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	2,721	345,038				12.00
13.00	01300	NURSING ADMINISTRATION	248,567	0	13,408,348			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,998	0	0	4,240,955		14.00
15.00	01500	PHARMACY	133,034	0	0	0	-3,898,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,236	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	8,007	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	825,082	0	3,818,687	104,497	0	30.00
31.00	03100	INTENSIVE CARE UNIT	141,625	0	870,007	31,543	0	31.00
43.00	04300	NURSERY	43,579	0	349,562	6,235	0	43.00
44.00	04400	SKILLED NURSING FACILITY	137,101	0	525,637	16,571	0	44.00
45.00	04500	NURSING FACILITY	156,738	0	311,683	7,226	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	567,934	0	2,658,229	1,091,534	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	141,874	0	743,416	48,172	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	444,618	0	139,452	299,847	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	57,110	0	90,578	4,763	0	55.00
57.00	05700	CT SCAN	50,805	0	15,373	27,195	0	57.00
58.00	05800	MRI	127,221	0	11,271	36,963	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	70,271	0	255,270	219,495	0	59.00
60.00	06000	LABORATORY	271,682	86,260	0	227,686	0	60.00
65.00	06500	RESPIRATORY THERAPY	69,942	0	0	25,826	0	65.00
66.00	06600	PHYSICAL THERAPY	198,922	86,260	0	3,256	0	66.00
68.00	06800	SPEECH PATHOLOGY	61,263	0	0	38,288	0	68.00
69.00	06900	ELECTROCARDIOLOGY	45,529	0	684	3,073	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,674	0	0	3,047	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	948,544	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	905,297	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	37,170	0	146,214	1,263	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	91,660	0	491,952	22,028	0	90.01
90.02	09002	WOUND CLINIC	29,078	0	94,865	31,610	0	90.02
91.00	09100	EMERGENCY	323,373	172,518	1,693,431	121,761	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	102,927	0	491,915	7,467	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	169,839	0	646,629	7,424	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,723,580	345,038	13,354,855	4,240,611	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,665	0	53,493	65	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,901	0	0	279	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	-3,898,905	201.00
202.00		TOTAL (sum lines 118-201)	4,746,146	345,038	13,408,348	4,240,955	-3,898,905	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			16.00	17.00	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	2,188,561					16.00
17.00	01700	SOCIAL SERVICE	0	465,698				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,910,773			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		894,284		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	127,009	465,698	1,910,773	894,284	41,351,337	30.00
31.00	03100	INTENSIVE CARE UNIT	32,611	0	0	0	8,046,896	31.00
43.00	04300	NURSERY	10,741	0	0	0	3,650,238	43.00
44.00	04400	SKILLED NURSING FACILITY	17,390	0	0	0	8,549,443	44.00
45.00	04500	NURSING FACILITY	4,943	0	0	0	9,753,735	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	310,818	0	0	0	37,361,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	32,693	0	0	0	7,639,831	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	231,845	0	0	0	24,523,260	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	58,594	0	0	0	5,199,865	55.00
57.00	05700	CT SCAN	99,773	0	0	0	1,942,228	57.00
58.00	05800	MRI	143,427	0	0	0	6,255,902	58.00
59.00	05900	CARDIAC CATHETERIZATION	42,611	0	0	0	3,561,983	59.00
60.00	06000	LABORATORY	236,719	0	0	0	17,551,341	60.00
65.00	06500	RESPIRATORY THERAPY	26,889	0	0	0	2,761,759	65.00
66.00	06600	PHYSICAL THERAPY	45,303	0	0	0	9,223,119	66.00
68.00	06800	SPEECH PATHOLOGY	9,232	0	0	0	3,411,840	68.00
69.00	06900	ELECTROCARDIOLOGY	61,498	0	0	0	2,222,955	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,871	0	0	0	1,086,762	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	102,520	0	0	0	12,802,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,149	0	0	0	11,118,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	275,296	0	0	0	60,889,694	73.00
76.97	07697	CARDIAC REHABILITATION	3,485	0	0	0	1,623,812	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	14,579	0	0	0	4,578,327	90.01
90.02	09002	WOUND CLINIC	10,437	0	0	0	2,530,404	90.02
91.00	09100	EMERGENCY	226,483	0	0	0	16,409,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	15,763	0	0	0	4,440,938	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,882	0	0	0	4,675,353	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,188,561	465,698	1,910,773	894,284	313,162,832	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	270,230	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	-721,310	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	95,001	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	31,871	194.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	-6,651,313	201.00
202.00		TOTAL (sum lines 118-201)	2,188,561	465,698	1,910,773	894,284	306,187,311	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part I | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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 APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,805,057	38,546,280		30.00
31.00	03100	INTENSIVE CARE UNIT	0	8,046,896		31.00
43.00	04300	NURSERY	0	3,650,238		43.00
44.00	04400	SKILLED NURSING FACILITY	0	8,549,443		44.00
45.00	04500	NURSING FACILITY	0	9,753,735		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	37,361,508		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,639,831		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,523,260		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	5,199,865		55.00
57.00	05700	CT SCAN	0	1,942,228		57.00
58.00	05800	MRI	0	6,255,902		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,561,983		59.00
60.00	06000	LABORATORY	0	17,551,341		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,761,759		65.00
66.00	06600	PHYSICAL THERAPY	0	9,223,119		66.00
68.00	06800	SPEECH PATHOLOGY	0	3,411,840		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,222,955		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,086,762		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,802,477		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,118,597		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	60,889,694		73.00
76.97	07697	CARDIAC REHABILITATION	0	1,623,812		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0	4,578,327		90.01
90.02	09002	WOUND CLINIC	0	2,530,404		90.02
91.00	09100	EMERGENCY	0	16,409,228		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	4,440,938		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	4,675,353		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,805,057	310,357,775		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	270,230		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-721,310		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	95,001		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	31,871		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	-6,651,313		201.00
202.00		TOTAL (sum lines 118-201)	-2,805,057	303,382,254		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	37,025	92,365	0	129,390	129,390	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,911,917	659,701	173,723	5,745,341	0	5.00
7.00	00700	OPERATION OF PLANT	44,872	2,035,781	184,020	2,264,673	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,280	12,983	39,263	0	8.00
9.00	00900	HOUSEKEEPING	0	100,463	4,291	104,754	0	9.00
10.00	01000	DIETARY	0	71,455	1,252	72,707	0	10.00
11.00	01100	CAFETERIA	0	19,967	1,724	21,691	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	11,440	96,569	0	108,009	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	17,896	5,661	23,557	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	149,608	160,430	92,853	402,891	0	14.00
15.00	01500	PHARMACY	0	33,792	98,952	132,744	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,357	0	39,357	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	31,021	31,021	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	254,172	45,111	299,283	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	45,693	26,043	71,736	0	31.00
43.00	04300	NURSERY	0	5,409	18,549	23,958	0	43.00
44.00	04400	SKILLED NURSING FACILITY	45,532	152,288	8,537	206,357	0	44.00
45.00	04500	NURSING FACILITY	0	254,867	2,190	257,057	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,279	754,920	1,790,522	2,555,721	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662	84,397	76,218	161,277	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	234,142	1,717,971	1,952,113	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	145,318	599,089	744,407	0	55.00
57.00	05700	CT SCAN	750	10,867	31,594	43,211	0	57.00
58.00	05800	MRI	0	210,372	450,474	660,846	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	31,989	72,531	104,520	0	59.00
60.00	06000	LABORATORY	42,810	143,046	206,888	392,744	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,064	32,538	34,602	0	65.00
66.00	06600	PHYSICAL THERAPY	580	191,138	7,909	199,627	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	182,179	13,727	195,906	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	64,158	91,059	155,217	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	33,981	29,886	63,867	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	9,244	8,702	17,946	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	95,430	3,586	99,016	0	90.01
90.02	09002	WOUND CLINIC	0	13,377	8,327	21,704	0	90.02
91.00	09100	EMERGENCY	0	228,284	109,231	337,515	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	7,275	49,176	12,365	68,816	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	501	6,394	6,895	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,262,750	6,551,068	5,975,921	17,789,739	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,918	555	9,473	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,042,313	2,831,021	0	3,873,334	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	19,450	0	19,450	0	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	129,390	201.00
202.00		TOTAL (sum lines 118-201)	6,305,063	9,410,457	5,976,476	21,691,996	129,390	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,745,341					5.00
7.00	00700	OPERATION OF PLANT	511,560	2,776,233				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,940	0	59,203			8.00
9.00	00900	HOUSEKEEPING	114,954	48,181	29,601	297,490		9.00
10.00	01000	DIETARY	34,089	23,694	0	4,535	135,025	10.00
11.00	01100	CAFETERIA	70,712	83,819	0	1,209	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	4,142	9,980	0	605	0	12.00
13.00	01300	NURSING ADMINISTRATION	219,525	113,272	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70,545	20,991	0	3,023	0	14.00
15.00	01500	PHARMACY	0	74,723	0	1,814	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,945	21,597	0	6,651	0	16.00
17.00	01700	SOCIAL SERVICE	0	46,168	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	34,905	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	16,190	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	448,561	298,140	16,190	169,907	70,716	30.00
31.00	03100	INTENSIVE CARE UNIT	107,837	53,600	1,792	13,605	9,699	31.00
43.00	04300	NURSERY	54,732	6,345	4,109	4,233	0	43.00
44.00	04400	SKILLED NURSING FACILITY	96,050	178,635	436	9,674	33,299	44.00
45.00	04500	NURSING FACILITY	113,421	298,955	2,642	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	504,223	430,064	1,011	31,442	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103,259	98,995	1,221	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	394,146	163,828	0	7,256	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	78,644	67,779	0	0	0	55.00
57.00	05700	CT SCAN	29,603	12,745	0	0	0	57.00
58.00	05800	MRI	98,155	55,898	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	47,419	37,525	0	0	0	59.00
60.00	06000	LABORATORY	281,972	106,078	0	9,070	0	60.00
65.00	06500	RESPIRATORY THERAPY	46,539	2,424	0	2,721	0	65.00
66.00	06600	PHYSICAL THERAPY	133,240	149,606	251	3,326	0	66.00
68.00	06800	SPEECH PATHOLOGY	48,367	64,973	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,932	19,821	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,114	39,858	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	214,669	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	185,930	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,107,341	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	24,187	10,844	122	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	57,606	45,089	0	14,209	0	90.01
90.02	09002	WOUND CLINIC	39,685	15,691	1,828	0	0	90.02
91.00	09100	EMERGENCY	218,765	159,190	0	11,791	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	60,285	17,140	0	0	21,311	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	70,087	585	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,740,276	2,776,233	59,203	295,071	135,025	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,748	0	0	2,419	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	1,735	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	582	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,745,341	2,776,233	59,203	297,490	135,025	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	177,431					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	102	122,838				12.00
13.00	01300	NURSING ADMINISTRATION	9,292	0	365,646			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,477	0	0	500,927		14.00
15.00	01500	PHARMACY	4,973	0	0	0	214,254	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,177	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	299	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,844	0	104,134	12,343	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,295	0	23,725	3,726	0	31.00
43.00	04300	NURSERY	1,629	0	9,533	737	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,125	0	14,334	1,957	0	44.00
45.00	04500	NURSING FACILITY	5,860	0	8,500	854	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,232	0	72,490	128,921	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,304	0	20,273	5,690	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,622	0	3,803	35,417	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,135	0	2,470	563	0	55.00
57.00	05700	CT SCAN	1,899	0	419	3,212	0	57.00
58.00	05800	MRI	4,756	0	307	4,366	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,627	0	6,961	25,926	0	59.00
60.00	06000	LABORATORY	10,157	30,710	0	26,894	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,615	0	0	3,051	0	65.00
66.00	06600	PHYSICAL THERAPY	7,437	30,710	0	385	0	66.00
68.00	06800	SPEECH PATHOLOGY	2,290	0	0	4,523	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,702	0	19	363	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	549	0	0	360	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	112,040	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	106,932	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,390	0	3,987	149	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	3,427	0	13,416	2,602	0	90.01
90.02	09002	WOUND CLINIC	1,087	0	2,587	3,734	0	90.02
91.00	09100	EMERGENCY	12,089	61,418	46,180	14,382	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,848	0	13,415	882	0	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,349	0	17,634	877	0	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	176,588	122,838	364,187	500,886	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	249	0	1,459	8	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	594	0	0	33	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	214,254	201.00
202.00		TOTAL (sum lines 118-201)	177,431	122,838	365,646	500,927	214,254	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	
			16.00	17.00	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	101,727					16.00
17.00	01700	SOCIAL SERVICE	0	46,168				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	34,905			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		47,510		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,924	46,168			1,502,210	30.00
31.00	03100	INTENSIVE CARE UNIT	1,521	0			292,536	31.00
43.00	04300	NURSERY	501	0			105,777	43.00
44.00	04400	SKILLED NURSING FACILITY	811	0			546,678	44.00
45.00	04500	NURSING FACILITY	231	0			687,520	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,140	0			3,759,244	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,525	0			397,544	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,814	0			2,583,999	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,733	0			898,731	55.00
57.00	05700	CT SCAN	4,654	0			95,743	57.00
58.00	05800	MRI	6,690	0			831,018	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,988	0			226,966	59.00
60.00	06000	LABORATORY	11,042	0			868,667	60.00
65.00	06500	RESPIRATORY THERAPY	1,254	0			93,206	65.00
66.00	06600	PHYSICAL THERAPY	2,113	0			526,695	66.00
68.00	06800	SPEECH PATHOLOGY	431	0			316,490	68.00
69.00	06900	ELECTROCARDIOLOGY	2,869	0			214,923	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	181	0			116,929	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,782	0			331,491	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,639	0			294,501	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,841	0			1,120,182	73.00
76.97	07697	CARDIAC REHABILITATION	163	0			58,788	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	680	0			236,045	90.01
90.02	09002	WOUND CLINIC	487	0			86,803	90.02
91.00	09100	EMERGENCY	10,564	0			871,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	735	0			186,432	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	414	0			102,841	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	101,727	46,168	0	0	17,353,853	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			16,356	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0			3,873,961	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0			1,735	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0			20,032	194.01
200.00		Cross Foot Adjustments			34,905	47,510	82,415	200.00
201.00		Negative Cost Centers	0	0	0	0	343,644	201.00
202.00		TOTAL (sum lines 118-201)	101,727	46,168	34,905	47,510	21,691,996	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B Part II | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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 APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,502,210		30.00
31.00	03100	INTENSIVE CARE UNIT	0	292,536		31.00
43.00	04300	NURSERY	0	105,777		43.00
44.00	04400	SKILLED NURSING FACILITY	0	546,678		44.00
45.00	04500	NURSING FACILITY	0	687,520		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,759,244		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	397,544		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,583,999		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	898,731		55.00
57.00	05700	CT SCAN	0	95,743		57.00
58.00	05800	MRI	0	831,018		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	226,966		59.00
60.00	06000	LABORATORY	0	868,667		60.00
65.00	06500	RESPIRATORY THERAPY	0	93,206		65.00
66.00	06600	PHYSICAL THERAPY	0	526,695		66.00
68.00	06800	SPEECH PATHOLOGY	0	316,490		68.00
69.00	06900	ELECTROCARDIOLOGY	0	214,923		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	116,929		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	331,491		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	294,501		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,120,182		73.00
76.97	07697	CARDIAC REHABILITATION	0	58,788		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0	236,045		90.01
90.02	09002	WOUND CLINIC	0	86,803		90.02
91.00	09100	EMERGENCY	0	871,894		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	186,432		92.01
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	102,841		101.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	17,353,853		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,356		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,873,961		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	1,735		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	20,032		194.01
200.00		Cross Foot Adjustments	0	82,415		200.00
201.00		Negative Cost Centers	0	343,644		201.00
202.00		TOTAL (sum lines 118-201)	0	21,691,996		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (DV SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	9,380,456					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,939,035				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	92,071	0	87,517,360			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	657,598	172,635	12,100,606	-121,538,258	192,969,282	5.00
7.00	00700	OPERATION OF PLANT	2,029,291	182,867	3,672,841	0	17,181,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,196	12,902	302,139	0	669,735	8.00
9.00	00900	HOUSEKEEPING	100,143	4,264	1,651,221	0	3,861,024	9.00
10.00	01000	DIETARY	71,227	1,244	10,372	0	1,144,964	10.00
11.00	01100	CAFETERIA	19,903	1,713	0	0	2,375,025	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	96,261	0	29,745	0	139,130	12.00
13.00	01300	NURSING ADMINISTRATION	17,839	5,626	5,142,298	0	7,373,281	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	159,919	92,271	849,188	0	2,369,436	14.00
15.00	01500	PHARMACY	33,684	98,332	2,627,828	4,830,331	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	39,232	0	675,813	0	1,072,941	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	1,172,374	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	30,827	86,763	0	543,784	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	253,362	44,828	11,249,688	0	15,066,048	30.00
31.00	03100	INTENSIVE CARE UNIT	45,547	25,880	2,273,791	0	3,621,978	31.00
43.00	04300	NURSERY	5,392	18,433	814,803	0	1,838,323	43.00
44.00	04400	SKILLED NURSING FACILITY	151,803	8,484	2,059,680	0	3,226,069	44.00
45.00	04500	NURSING FACILITY	254,055	2,176	1,869,285	0	3,809,522	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	752,513	1,779,301	8,227,213	0	16,935,587	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,128	75,741	221,135	0	3,468,216	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,396	1,707,209	6,732,342	0	13,238,371	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	144,855	595,336	975,970	0	2,641,457	55.00
57.00	05700	CT SCAN	10,832	31,396	740,303	0	994,288	57.00
58.00	05800	MRI	209,701	447,652	1,939,836	0	3,296,769	58.00
59.00	05900	CARDIAC CATHETERIZATION	31,887	72,077	1,290,232	0	1,592,692	59.00
60.00	06000	LABORATORY	142,590	205,592	3,368,467	0	9,470,719	60.00
65.00	06500	RESPIRATORY THERAPY	2,057	32,334	1,083,245	0	1,563,143	65.00
66.00	06600	PHYSICAL THERAPY	190,529	7,859	3,416,330	0	4,475,183	66.00
68.00	06800	SPEECH PATHOLOGY	181,598	13,641	905,942	0	1,624,511	68.00
69.00	06900	ELECTROCARDIOLOGY	63,953	90,489	754,379	0	1,173,271	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,873	29,699	216,181	0	406,864	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,210,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,244,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	37,190,563	73.00
76.97	07697	CARDIAC REHABILITATION	9,215	8,647	608,951	0	812,385	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	95,126	3,564	1,345,350	0	1,934,828	90.01
90.02	09002	WOUND CLINIC	13,334	8,275	448,929	0	1,332,924	90.02
91.00	09100	EMERGENCY	227,556	108,547	5,144,386	0	7,347,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	49,019	12,288	1,412,398	0	2,024,818	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	499	6,354	2,919,812	0	2,354,033	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,530,184	5,938,483	87,167,462	-116,707,927	192,799,123	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,890	552	138,444	0	92,315	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,821,994	0	211,454	737,490	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	58,289	194.00
194.01	07951	OCCUPATIONAL HEALTH	19,388	0	0	0	19,555	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	9,410,457	5,976,476	-2,752,408		121,538,258	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.003198	1.006304	0.000000		0.629832	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			129,390		5,745,341	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001478		0.029773	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	398,621					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,228,810				8.00
9.00	00900	HOUSEKEEPING	6,918	614,405	4,498,489			9.00
10.00	01000	DIETARY	3,402	0	68,575	107,757		10.00
11.00	01100	CAFETERIA	12,035	0	18,287	0	2,061,663	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	1,433	0	9,143	0	1,182	12.00
13.00	01300	NURSING ADMINISTRATION	16,264	0	0	0	107,974	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,014	0	45,716	0	40,397	14.00
15.00	01500	PHARMACY	10,729	0	27,430	0	57,788	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,101	0	100,576	0	25,297	16.00
17.00	01700	SOCIAL SERVICE	6,629	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	3,478	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,808	336,037	2,569,258	56,436	358,406	30.00
31.00	03100	INTENSIVE CARE UNIT	7,696	37,201	205,724	7,740	61,520	31.00
43.00	04300	NURSERY	911	85,277	64,003	0	18,930	43.00
44.00	04400	SKILLED NURSING FACILITY	25,649	9,049	146,292	26,574	59,555	44.00
45.00	04500	NURSING FACILITY	42,925	54,838	0	0	68,085	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,750	20,993	475,450	0	246,703	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,214	25,340	0	0	61,628	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,523	0	109,719	0	193,136	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	9,732	0	0	0	24,808	55.00
57.00	05700	CT SCAN	1,830	0	0	0	22,069	57.00
58.00	05800	MRI	8,026	0	0	0	55,263	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,388	0	0	0	30,525	59.00
60.00	06000	LABORATORY	15,231	0	137,149	0	118,015	60.00
65.00	06500	RESPIRATORY THERAPY	348	0	41,145	0	30,382	65.00
66.00	06600	PHYSICAL THERAPY	21,481	5,208	50,288	0	86,409	66.00
68.00	06800	SPEECH PATHOLOGY	9,329	0	0	0	26,612	68.00
69.00	06900	ELECTROCARDIOLOGY	2,846	0	0	0	19,777	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,723	0	0	0	6,374	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	1,557	2,530	0	0	16,146	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	6,474	0	214,867	0	39,816	90.01
90.02	09002	WOUND CLINIC	2,253	37,932	0	0	12,631	90.02
91.00	09100	EMERGENCY	22,857	0	178,294	0	140,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	2,461	0	0	17,007	44,710	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	84	0	0	0	73,776	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	398,621	1,228,810	4,461,916	107,757	2,051,861	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	36,573	0	2,895	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	6,907	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	28,003,772	1,091,556	7,324,599	2,216,751	4,746,146	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	70.251622	0.888303	1.628235	20.571759	2.302096	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,776,233	59,203	297,490	135,025	177,431	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.964593	0.048179	0.066131	1.253051	0.086062	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			12.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	1,012,080					12.00
13.00	01300	NURSING ADMINISTRATION	0	725,648				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	29,026,070			14.00
15.00	01500	PHARMACY	0	0	0	20,982,751		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,245,240,193	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	206,664	715,203	26,545	72,246,074	30.00
31.00	03100	INTENSIVE CARE UNIT	0	47,084	215,891	6,173	18,549,908	31.00
43.00	04300	NURSERY	0	18,918	42,677	146	6,110,063	43.00
44.00	04400	SKILLED NURSING FACILITY	0	28,447	113,416	553	9,891,654	44.00
45.00	04500	NURSING FACILITY	0	16,868	49,458	8	2,811,441	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	143,861	7,470,644	74,689	177,127,062	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,233	329,698	9,503	18,596,932	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,547	2,052,228	15,005	131,880,047	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,902	32,596	0	33,329,717	55.00
57.00	05700	CT SCAN	0	832	186,131	110	56,753,565	57.00
58.00	05800	MRI	0	610	252,982	2,001	81,585,605	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	13,815	1,502,277	1,882	24,238,489	59.00
60.00	06000	LABORATORY	253,020	0	1,558,340	15,214	134,652,569	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	176,760	521	15,295,203	65.00
66.00	06600	PHYSICAL THERAPY	253,020	0	22,283	0	25,769,616	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	262,053	3	5,251,685	68.00
69.00	06900	ELECTROCARDIOLOGY	0	37	21,031	801	34,981,958	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	20,857	0	2,201,651	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,492,075	0	58,316,419	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	6,196,078	0	19,993,483	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,749,118	156,595,932	73.00
76.97	07697	CARDIAC REHABILITATION	0	7,913	8,642	0	1,982,526	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	26,624	150,764	5,700	8,293,208	90.01
90.02	09002	WOUND CLINIC	0	5,134	216,350	1,851	5,936,623	90.02
91.00	09100	EMERGENCY	506,040	91,647	833,362	45,937	128,829,646	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	26,622	51,109	4,263	8,966,687	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	34,995	50,809	22,724	5,052,430	101.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,012,080	722,753	29,023,714	20,982,747	1,245,240,193	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,895	448	4	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,908	0	0	192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0	0	0	194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	345,038	13,408,348	4,240,955	-3,898,905	2,188,561	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.340920	18.477758	0.146108	0.000000	0.001758	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	122,838	365,646	500,927	214,254	101,727	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.121372	0.503889	0.017258	0.010211	0.000082	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet B-1 | Date/Time Prepared: 1/30/2018 10:32 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			17.00	21.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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	100				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	100			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		100		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	100	100	100		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		31.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0	0	0		90.01
90.02	09002	WOUND CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0		92.01
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	100		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
194.00	07950	HEALTH & FITNESS CENTER	0	0	0		194.00
194.01	07951	OCCUPATIONAL HEALTH	0	0	0		194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	465,698	1,910,773	894,284		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4,656.980000	19,107.730000	8,942.840000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	46,168	34,905	47,510		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	461.680000	349.050000	475.100000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/30/2018 10:32 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,546,280		38,546,280	0	38,546,280	30.00
31.00	03100	INTENSIVE CARE UNIT	8,046,896		8,046,896	0	8,046,896	31.00
43.00	04300	NURSERY	3,650,238		3,650,238	0	3,650,238	43.00
44.00	04400	SKILLED NURSING FACILITY	8,549,443		8,549,443	0	8,549,443	44.00
45.00	04500	NURSING FACILITY	9,753,735		9,753,735	0	9,753,735	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,361,508		37,361,508	0	37,361,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,639,831		7,639,831	0	7,639,831	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,523,260		24,523,260	0	24,523,260	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,199,865		5,199,865	0	5,199,865	55.00
57.00	05700	CT SCAN	1,942,228		1,942,228	0	1,942,228	57.00
58.00	05800	MRI	6,255,902		6,255,902	0	6,255,902	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,561,983		3,561,983	0	3,561,983	59.00
60.00	06000	LABORATORY	17,551,341		17,551,341	0	17,551,341	60.00
65.00	06500	RESPIRATORY THERAPY	2,761,759	0	2,761,759	0	2,761,759	65.00
66.00	06600	PHYSICAL THERAPY	9,223,119	0	9,223,119	0	9,223,119	66.00
68.00	06800	SPEECH PATHOLOGY	3,411,840	0	3,411,840	0	3,411,840	68.00
69.00	06900	ELECTROCARDIOLOGY	2,222,955		2,222,955	0	2,222,955	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,086,762		1,086,762	0	1,086,762	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,802,477		12,802,477	0	12,802,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,118,597		11,118,597	0	11,118,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,889,694		60,889,694	0	60,889,694	73.00
76.97	07697	CARDIAC REHABILITATION	1,623,812		1,623,812	0	1,623,812	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	4,578,327		4,578,327	0	4,578,327	90.01
90.02	09002	WOUND CLINIC	2,530,404		2,530,404	0	2,530,404	90.02
91.00	09100	EMERGENCY	16,409,228		16,409,228	0	16,409,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,819,651		6,819,651		6,819,651	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	4,440,938		4,440,938	0	4,440,938	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,675,353		4,675,353		4,675,353	101.00
200.00		Subtotal (see instructions)	317,177,426	0	317,177,426	0	317,177,426	200.00
201.00		Less Observation Beds	6,819,651		6,819,651		6,819,651	201.00
202.00		Total (see instructions)	310,357,775	0	310,357,775	0	310,357,775	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/30/2018 10:32 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,513,517		59,513,517			30.00
31.00	03100	INTENSIVE CARE UNIT	18,549,908		18,549,908			31.00
43.00	04300	NURSERY	6,110,063		6,110,063			43.00
44.00	04400	SKILLED NURSING FACILITY	9,891,654		9,891,654			44.00
45.00	04500	NURSING FACILITY	2,811,441		2,811,441			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,424,425	130,702,637	177,127,062	0.210931	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,519,319	1,077,613	18,596,932	0.410811	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,293,349	118,586,698	131,880,047	0.185951	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	687,093	32,642,624	33,329,717	0.156013	0.000000	55.00
57.00	05700	CT SCAN	15,928,979	40,824,586	56,753,565	0.034222	0.000000	57.00
58.00	05800	MRI	8,938,166	72,647,439	81,585,605	0.076679	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,676,444	11,562,045	24,238,489	0.146956	0.000000	59.00
60.00	06000	LABORATORY	47,284,862	87,367,707	134,652,569	0.130345	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,526,352	3,768,851	15,295,203	0.180564	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,074,073	13,695,543	25,769,616	0.357907	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	1,038,546	4,213,139	5,251,685	0.649666	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,916,461	25,065,497	34,981,958	0.063546	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	196,968	2,004,683	2,201,651	0.493612	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,843,431	32,472,988	58,316,419	0.219535	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,417,896	6,575,587	19,993,483	0.556111	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,446,670	139,149,262	156,595,932	0.388833	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	2,569	1,979,957	1,982,526	0.819062	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	36,629	8,256,579	8,293,208	0.552057	0.000000	90.01
90.02	09002	WOUND CLINIC	26,605	5,910,018	5,936,623	0.426236	0.000000	90.02
91.00	09100	EMERGENCY	19,290,779	109,538,867	128,829,646	0.127372	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,854,434	9,878,123	12,732,557	0.535607	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,501,642	5,465,045	8,966,687	0.495271	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,052,430	5,052,430			101.00
200.00		Subtotal (see instructions)	376,802,275	868,437,918	1,245,240,193			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	376,802,275	868,437,918	1,245,240,193			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/30/2018 10:32 am

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
45.00	04500	NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.210931
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.410811
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185951
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156013
57.00	05700	CT SCAN	0.034222
58.00	05800	MRI	0.076679
59.00	05900	CARDIAC CATHETERIZATION	0.146956
60.00	06000	LABORATORY	0.130345
65.00	06500	RESPIRATORY THERAPY	0.180564
66.00	06600	PHYSICAL THERAPY	0.357907
68.00	06800	SPEECH PATHOLOGY	0.649666
69.00	06900	ELECTROCARDIOLOGY	0.063546
70.00	07000	ELECTROENCEPHALOGRAPHY	0.493612
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.219535
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556111
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388833
76.97	07697	CARDIAC REHABILITATION	0.819062
		OUTPATIENT SERVICE COST CENTERS	
90.01	09001	OP PEDS ONC CLINIC	0.552057
90.02	09002	WOUND CLINIC	0.426236
91.00	09100	EMERGENCY	0.127372
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.535607
92.01	09201	OBSERVATION BEDS-DISTINCT	0.495271
		OTHER REIMBURSABLE COST CENTERS	
101.00	10100	HOME HEALTH AGENCY	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/30/2018 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	38,546,280		38,546,280	0	38,546,280	30.00
31.00	03100	INTENSIVE CARE UNIT	8,046,896		8,046,896	0	8,046,896	31.00
43.00	04300	NURSERY	3,650,238		3,650,238	0	3,650,238	43.00
44.00	04400	SKILLED NURSING FACILITY	8,549,443		8,549,443	0	8,549,443	44.00
45.00	04500	NURSING FACILITY	9,753,735		9,753,735	0	9,753,735	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,361,508		37,361,508	0	37,361,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,639,831		7,639,831	0	7,639,831	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,523,260		24,523,260	0	24,523,260	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,199,865		5,199,865	0	5,199,865	55.00
57.00	05700	CT SCAN	1,942,228		1,942,228	0	1,942,228	57.00
58.00	05800	MRI	6,255,902		6,255,902	0	6,255,902	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,561,983		3,561,983	0	3,561,983	59.00
60.00	06000	LABORATORY	17,551,341		17,551,341	0	17,551,341	60.00
65.00	06500	RESPIRATORY THERAPY	2,761,759	0	2,761,759	0	2,761,759	65.00
66.00	06600	PHYSICAL THERAPY	9,223,119	0	9,223,119	0	9,223,119	66.00
68.00	06800	SPEECH PATHOLOGY	3,411,840	0	3,411,840	0	3,411,840	68.00
69.00	06900	ELECTROCARDIOLOGY	2,222,955		2,222,955	0	2,222,955	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,086,762		1,086,762	0	1,086,762	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,802,477		12,802,477	0	12,802,477	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,118,597		11,118,597	0	11,118,597	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,889,694		60,889,694	0	60,889,694	73.00
76.97	07697	CARDIAC REHABILITATION	1,623,812		1,623,812	0	1,623,812	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	4,578,327		4,578,327	0	4,578,327	90.01
90.02	09002	WOUND CLINIC	2,530,404		2,530,404	0	2,530,404	90.02
91.00	09100	EMERGENCY	16,409,228		16,409,228	0	16,409,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,819,651		6,819,651		6,819,651	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	4,440,938		4,440,938	0	4,440,938	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,675,353		4,675,353		4,675,353	101.00
200.00		Subtotal (see instructions)	317,177,426	0	317,177,426	0	317,177,426	200.00
201.00		Less Observation Beds	6,819,651		6,819,651		6,819,651	201.00
202.00		Total (see instructions)	310,357,775	0	310,357,775	0	310,357,775	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/30/2018 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,513,517		59,513,517			30.00
31.00	03100	INTENSIVE CARE UNIT	18,549,908		18,549,908			31.00
43.00	04300	NURSERY	6,110,063		6,110,063			43.00
44.00	04400	SKILLED NURSING FACILITY	9,891,654		9,891,654			44.00
45.00	04500	NURSING FACILITY	2,811,441		2,811,441			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	46,424,425	130,702,637	177,127,062	0.210931	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,519,319	1,077,613	18,596,932	0.410811	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,293,349	118,586,698	131,880,047	0.185951	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	687,093	32,642,624	33,329,717	0.156013	0.000000	55.00
57.00	05700	CT SCAN	15,928,979	40,824,586	56,753,565	0.034222	0.000000	57.00
58.00	05800	MRI	8,938,166	72,647,439	81,585,605	0.076679	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,676,444	11,562,045	24,238,489	0.146956	0.000000	59.00
60.00	06000	LABORATORY	47,284,862	87,367,707	134,652,569	0.130345	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	11,526,352	3,768,851	15,295,203	0.180564	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,074,073	13,695,543	25,769,616	0.357907	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	1,038,546	4,213,139	5,251,685	0.649666	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	9,916,461	25,065,497	34,981,958	0.063546	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	196,968	2,004,683	2,201,651	0.493612	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,843,431	32,472,988	58,316,419	0.219535	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,417,896	6,575,587	19,993,483	0.556111	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,446,670	139,149,262	156,595,932	0.388833	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	2,569	1,979,957	1,982,526	0.819062	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	36,629	8,256,579	8,293,208	0.552057	0.000000	90.01
90.02	09002	WOUND CLINIC	26,605	5,910,018	5,936,623	0.426236	0.000000	90.02
91.00	09100	EMERGENCY	19,290,779	109,538,867	128,829,646	0.127372	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,854,434	9,878,123	12,732,557	0.535607	0.000000	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	3,501,642	5,465,045	8,966,687	0.495271	0.000000	92.01
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,052,430	5,052,430			101.00
200.00		Subtotal (see instructions)	376,802,275	868,437,918	1,245,240,193			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	376,802,275	868,437,918	1,245,240,193			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet C Part I Date/Time Prepared: 1/30/2018 10:32 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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 PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
90.01	09001	OP PEDS ONC CLINIC	0.000000		90.01
90.02	09002	WOUND CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.000000		92.01
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
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: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part I Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,502,210	0	1,502,210	24,559	61.17	30.00
31.00	INTENSIVE CARE UNIT	292,536		292,536	2,620	111.65	31.00
43.00	NURSERY	105,777		105,777	3,658	28.92	43.00
44.00	SKILLED NURSING FACILITY	546,678		546,678	7,932	68.92	44.00
45.00	NURSING FACILITY	687,520		687,520	0	0.00	45.00
200.00	Total (lines 30-199)	3,134,721		3,134,721	38,769		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	8,627	527,714	30.00
31.00	INTENSIVE CARE UNIT	1,381	154,189	31.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	6,648	458,180	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	16,656	1,140,083	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part II Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,759,244	177,127,062	0.021223	20,500,485	435,082	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	397,544	18,596,932	0.021377	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,583,999	131,880,047	0.019594	6,657,909	130,455	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	898,731	33,329,717	0.026965	344,047	9,277	55.00
57.00	05700	CT SCAN	95,743	56,753,565	0.001687	7,837,686	13,222	57.00
58.00	05800	MRI	831,018	81,585,605	0.010186	3,750,316	38,201	58.00
59.00	05900	CARDIAC CATHETERIZATION	226,966	24,238,489	0.009364	6,423,424	60,149	59.00
60.00	06000	LABORATORY	868,667	134,652,569	0.006451	23,125,314	149,181	60.00
65.00	06500	RESPIRATORY THERAPY	93,206	15,295,203	0.006094	11,069,744	67,459	65.00
66.00	06600	PHYSICAL THERAPY	526,695	25,769,616	0.020439	2,966,405	60,630	66.00
68.00	06800	SPEECH PATHOLOGY	316,490	5,251,685	0.060264	483,634	29,146	68.00
69.00	06900	ELECTROCARDIOLOGY	214,923	34,981,958	0.006144	5,526,809	33,957	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	116,929	2,201,651	0.053110	97,352	5,170	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	331,491	58,316,419	0.005684	10,519,233	59,791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	294,501	19,993,483	0.014730	6,452,868	95,051	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,120,182	156,595,932	0.007153	6,400,548	45,783	73.00
76.97	07697	CARDIAC REHABILITATION	58,788	1,982,526	0.029653	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	236,045	8,293,208	0.028462	16,066	457	90.01
90.02	09002	WOUND CLINIC	86,803	5,936,623	0.014622	15,605	228	90.02
91.00	09100	EMERGENCY	871,894	128,829,646	0.006768	8,622,293	58,356	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	265,775	12,732,557	0.020874	1,327,714	27,715	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	186,432	8,966,687	0.020792	572,377	11,901	92.01
200.00		Total (lines 50-199)	14,382,066	1,143,311,180		122,709,829	1,331,211	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part III Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
45.00	04500	NURSING FACILITY	0	0			0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,559	0.00	8,627	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,620	0.00	1,381	0		31.00
43.00	04300	NURSERY	3,658	0.00	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	7,932	0.00	6,648	0		44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	38,769		16,656	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	177,127,062	0.000000	0.000000	20,500,485	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,596,932	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	131,880,047	0.000000	0.000000	6,657,909	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	33,329,717	0.000000	0.000000	344,047	55.00
57.00	05700	CT SCAN	0	56,753,565	0.000000	0.000000	7,837,686	57.00
58.00	05800	MRI	0	81,585,605	0.000000	0.000000	3,750,316	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,238,489	0.000000	0.000000	6,423,424	59.00
60.00	06000	LABORATORY	0	134,652,569	0.000000	0.000000	23,125,314	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,295,203	0.000000	0.000000	11,069,744	65.00
66.00	06600	PHYSICAL THERAPY	0	25,769,616	0.000000	0.000000	2,966,405	66.00
68.00	06800	SPEECH PATHOLOGY	0	5,251,685	0.000000	0.000000	483,634	68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,981,958	0.000000	0.000000	5,526,809	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,201,651	0.000000	0.000000	97,352	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	58,316,419	0.000000	0.000000	10,519,233	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,993,483	0.000000	0.000000	6,452,868	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	156,595,932	0.000000	0.000000	6,400,548	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,982,526	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	8,293,208	0.000000	0.000000	16,066	90.01
90.02	09002	WOUND CLINIC	0	5,936,623	0.000000	0.000000	15,605	90.02
91.00	09100	EMERGENCY	0	128,829,646	0.000000	0.000000	8,622,293	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,732,557	0.000000	0.000000	1,327,714	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	8,966,687	0.000000	0.000000	572,377	92.01
200.00		Total (lines 50-199)	0	1,143,311,180			122,709,829	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	29,077,882	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,519,158	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	12,773,427	0		55.00
57.00	05700	CT SCAN	0	12,634,098	0		57.00
58.00	05800	MRI	0	20,434,654	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	5,680,108	0		59.00
60.00	06000	LABORATORY	0	16,933,117	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,382,518	0		65.00
66.00	06600	PHYSICAL THERAPY	0	635,780	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	332,039	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,702,232	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	660,019	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,417,778	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,022,829	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	56,754,514	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	1,194,187	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0	3,014,047	0		90.01
90.02	09002	WOUND CLINIC	0	2,681,344	0		90.02
91.00	09100	EMERGENCY	0	15,791,680	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	3,053,966	0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	2,011,712	0		92.01
200.00		Total (lines 50-199)	0	235,707,089	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.210931	29,077,882	0	0	6,133,427	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.410811	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185951	32,519,158	0	0	6,046,970	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156013	12,773,427	0	0	1,992,821	55.00
57.00	05700	CT SCAN	0.034222	12,634,098	0	0	432,364	57.00
58.00	05800	MRI	0.076679	20,434,654	0	0	1,566,909	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.146956	5,680,108	0	0	834,726	59.00
60.00	06000	LABORATORY	0.130345	16,933,117	2,311	0	2,207,147	60.00
65.00	06500	RESPIRATORY THERAPY	0.180564	1,382,518	0	0	249,633	65.00
66.00	06600	PHYSICAL THERAPY	0.357907	635,780	0	0	227,550	66.00
68.00	06800	SPEECH PATHOLOGY	0.649666	332,039	0	0	215,714	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063546	8,702,232	0	0	552,992	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.493612	660,019	0	0	325,793	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.219535	7,417,778	0	0	1,628,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556111	2,022,829	0	0	1,124,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388833	56,754,514	288	15,376	22,068,028	73.00
76.97	07697	CARDIAC REHABILITATION	0.819062	1,194,187	0	0	978,113	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0.552057	3,014,047	0	0	1,663,926	90.01
90.02	09002	WOUND CLINIC	0.426236	2,681,344	0	0	1,142,885	90.02
91.00	09100	EMERGENCY	0.127372	15,791,680	0	0	2,011,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.535607	3,053,966	0	0	1,635,726	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.495271	2,011,712	0	0	996,343	92.01
200.00		Subtotal (see instructions)		235,707,089	2,599	15,376	54,035,864	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		235,707,089	2,599	15,376	54,035,864	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part V Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	301	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	112	5,979		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0	0		90.01
90.02	09002	WOUND CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0		92.01
200.00		Subtotal (see instructions)	413	5,979		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	413	5,979		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130 | Component CCN: 14-5216 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	0	0	0	0	90.01
90.02	09002	WOUND CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0	0	0	92.01
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130 | Component CCN: 14-5216 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	177,127,062	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,596,932	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	131,880,047	0.000000	0.000000	257,010	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	33,329,717	0.000000	0.000000	0	55.00
57.00	05700	CT SCAN	0	56,753,565	0.000000	0.000000	39,078	57.00
58.00	05800	MRI	0	81,585,605	0.000000	0.000000	23,498	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	24,238,489	0.000000	0.000000	8,389	59.00
60.00	06000	LABORATORY	0	134,652,569	0.000000	0.000000	1,165,929	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,295,203	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,769,616	0.000000	0.000000	5,996,723	66.00
68.00	06800	SPEECH PATHOLOGY	0	5,251,685	0.000000	0.000000	282,901	68.00
69.00	06900	ELECTROCARDIOLOGY	0	34,981,958	0.000000	0.000000	11,285	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,201,651	0.000000	0.000000	1,132	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	58,316,419	0.000000	0.000000	80,609	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,993,483	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	156,595,932	0.000000	0.000000	1,103,398	73.00
76.97	07697	CARDIAC REHABILITATION	0	1,982,526	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OP PEDS ONC CLINIC	0	8,293,208	0.000000	0.000000	0	90.01
90.02	09002	WOUND CLINIC	0	5,936,623	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	128,829,646	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,732,557	0.000000	0.000000	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	8,966,687	0.000000	0.000000	0	92.01
200.00		Total (lines 50-199)	0	1,143,311,180			8,969,952	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0130 | Component CCN: 14-5216 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D Part IV Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OP PEDS ONC CLINIC	0	0	0		90.01
90.02	09002	WOUND CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0	0	0		92.01
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	24,559	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,559	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	20,214	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,627	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)	38,546,280	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	38,546,280	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	38,546,280	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)	1,569.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	13,540,422	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)	13,540,422	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,046,896	2,620	3,071.33	1,381	4,241,507	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)	24,398,855	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	42,180,784	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)	681,903	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1,331,211	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	2,013,114	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	40,167,670	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)	4,345	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,569.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,819,651	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,502,210	38,546,280	0.038972	6,819,651	265,775	90.00
91.00	Nursing School cost	0	38,546,280	0.000000	6,819,651	0	91.00
92.00	Allied health cost	0	38,546,280	0.000000	6,819,651	0	92.00
93.00	All other Medical Education	0	38,546,280	0.000000	6,819,651	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0130 Component CCN: 14-5216	Period: From 09/01/2016 To 08/31/2017	Worksheet D-1 Date/Time Prepared: 1/30/2018 10:32 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,932	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,932	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,932	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)	6,648	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)	8,549,443	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	8,549,443	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	8,549,443	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Component CCN: 14-5216 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	8,549,443	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	1,077.84	71.00
72.00	Program routine service cost (line 9 x line 71)	7,165,480	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	7,165,480	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	7,165,480	83.00
84.00	Program inpatient ancillary services (see instructions)	2,982,206	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	10,147,686	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: 14-0130 | Component CCN: 14-5216 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XIX | Hospital | Cost

	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)	24,559	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,559	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	20,214	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)	901	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)	3,658	15.00
16.00	Nursery days (title V or XIX only)	163	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)	38,546,280	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	38,546,280	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	38,546,280	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)	1,569.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,414,156	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)	1,414,156	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XIX | Hospital | Cost

	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)	3,650,238	3,658	997.88	163	162,654	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	8,046,896	2,620	3,071.33	117	359,346	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,936,156	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)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	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)	4,345	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,569.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	6,819,651	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-1 | Date/Time Prepared: 1/30/2018 10:32 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,502,210	38,546,280	0.038972	6,819,651	265,775	90.00
91.00	Nursing School cost	0	38,546,280	0.000000	6,819,651	0	91.00
92.00	Allied health cost	0	38,546,280	0.000000	6,819,651	0	92.00
93.00	All other Medical Education	0	38,546,280	0.000000	6,819,651	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		23,707,224		30.00
31.00	03100	INTENSIVE CARE UNIT		7,389,361		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.210931	20,500,485	4,324,188	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.410811	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185951	6,657,909	1,238,045	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156013	344,047	53,676	55.00
57.00	05700	CT SCAN	0.034222	7,837,686	268,221	57.00
58.00	05800	MRI	0.076679	3,750,316	287,570	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.146956	6,423,424	943,961	59.00
60.00	06000	LABORATORY	0.130345	23,125,314	3,014,269	60.00
65.00	06500	RESPIRATORY THERAPY	0.180564	11,069,744	1,998,797	65.00
66.00	06600	PHYSICAL THERAPY	0.357907	2,966,405	1,061,697	66.00
68.00	06800	SPEECH PATHOLOGY	0.649666	483,634	314,201	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063546	5,526,809	351,207	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.493612	97,352	48,054	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.219535	10,519,233	2,309,340	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556111	6,452,868	3,588,511	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388833	6,400,548	2,488,744	73.00
76.97	07697	CARDIAC REHABILITATION	0.819062	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0.552057	16,066	8,869	90.01
90.02	09002	WOUND CLINIC	0.426236	15,605	6,651	90.02
91.00	09100	EMERGENCY	0.127372	8,622,293	1,098,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.535607	1,327,714	711,133	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.495271	572,377	283,482	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		122,709,829	24,398,855	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)		122,709,829		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0130 | Component CCN: 14-5216 | Period: From 09/01/2016 To 08/31/2017 | Worksheet D-3 | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.210931	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.410811	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.185951	257,010	47,791	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.156013	0	0	55.00
57.00	05700	CT SCAN	0.034222	39,078	1,337	57.00
58.00	05800	MRI	0.076679	23,498	1,802	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.146956	8,389	1,233	59.00
60.00	06000	LABORATORY	0.130345	1,165,929	151,973	60.00
65.00	06500	RESPIRATORY THERAPY	0.180564	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.357907	5,996,723	2,146,269	66.00
68.00	06800	SPEECH PATHOLOGY	0.649666	282,901	183,791	68.00
69.00	06900	ELECTROCARDIOLOGY	0.063546	11,285	717	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.493612	1,132	559	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.219535	80,609	17,696	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556111	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.388833	1,103,398	429,038	73.00
76.97	07697	CARDIAC REHABILITATION	0.819062	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
90.01	09001	OP PEDS ONC CLINIC	0.552057	0	0	90.01
90.02	09002	WOUND CLINIC	0.426236	0	0	90.02
91.00	09100	EMERGENCY	0.127372	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.535607	0	0	92.00
92.01	09201	OBSERVATION BEDS-DISTINCT	0.495271	0	0	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,969,952	2,982,206	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)		8,969,952		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part A Date/Time Prepared: 1/30/2018 10:32 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	1,775,035	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	20,582,814	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,016,219	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	1,981,452	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	110.55	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	17.03	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	17.03	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	17.03	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.154048	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.087298	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.087298	21.00
22.00	IME payment adjustment (see instructions)	1,040,646	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	92,227	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	17.03	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)	1,040,646	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	92,227	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)	11.20	31.00
32.00	Sum of lines 30 and 31	14.04	32.00
33.00	Allowable disproportionate share percentage (see instructions)	0.00	33.00
34.00	Disproportionate share adjustment (see instructions)	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E Part A Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	24,414,714		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)		24,506,941	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,049,684	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).		394,790	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		2,071	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		26,953,486	59.00
60.00	Primary payer payments		10,988	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		26,942,498	61.00
62.00	Deductibles billed to program beneficiaries		2,487,156	62.00
63.00	Coinsurance billed to program beneficiaries		44,149	63.00
64.00	Allowable bad debts (see instructions)		130,367	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		84,739	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		108,312	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		24,495,932	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		49,448	70.93
70.94	HRR adjustment amount (see instructions)		-454,113	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part A Date/Time Prepared: 1/30/2018 10:32 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		261,540	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23,829,727	71.00
71.01	Sequestration adjustment (see instructions)		476,595	71.01
72.00	Interim payments		22,961,711	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		391,421	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		282,573	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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/30/2018 10:32 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,775,035	0	1,775,035		1,775,035	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	20,582,814	0		20,582,814	20,582,814	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,016,219	0	125,796	890,423	1,016,219	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,981,452	0	115,520	1,865,932	1,981,452	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.087298	0.087298	0.087298	0.087298		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,040,646	0	82,619	958,027	1,040,646	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	92,227	0	0	92,227	92,227	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,040,646	0	82,619	958,027	1,040,646	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	92,227	0	0	92,227	92,227	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,414,714	0	1,983,450	22,431,264	24,414,714	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,506,941	0	1,983,450	22,523,491	24,506,941	15.00
16.00	Payment for inpatient program capital	50.00	2,049,684	0	163,162	1,886,522	2,049,684	16.00
17.00	Special add-on payments for new technologies	54.00	2,071	0	0	2,071	2,071	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/30/2018 10:32 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	2,146,612	24,412,084	26,558,696	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,808,309	0	142,346	1,665,963	1,808,309	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	51,503	0	5,869	45,634	51,503	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0762	0.0762	0.0762	0.0762		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	137,793	0	10,847	126,946	137,793	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0288	0.0288	0.0288	0.0288		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	52,079	0	4,100	47,979	52,079	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,049,684	0	163,162	1,886,522	2,049,684	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,775,035	1,775,035		1,775,035	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	20,582,814		20,582,814	20,582,814	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,016,219	125,796	890,423	1,016,219	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	1,981,452	115,520	1,865,932	1,981,452	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.087298	0.087298	0.087298		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,040,646	82,619	958,027	1,040,646	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	92,227	5,377	86,850	92,227	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1,040,646	82,619	958,027	1,040,646	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	92,227	5,377	86,850	92,227	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,414,714	1,983,450	22,431,264	24,414,714	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	24,506,941	1,988,827	22,518,114	24,506,941	15.00
16.00	Payment for inpatient program capital	50.00	2,049,684	163,162	1,886,522	2,049,684	16.00
17.00	Special add-on payments for new technologies	54.00	2,071	0	2,071	2,071	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,151,989	24,406,707	26,558,696	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,808,309	142,346	1,665,963	1,808,309	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	51,503	5,869	45,634	51,503	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0762	0.0762	0.0762		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	137,793	10,847	126,946	137,793	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0288	0.0288	0.0288		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	52,079	4,100	47,979	52,079	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,049,684	163,162	1,886,522	2,049,684	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	49,448	-5,467	54,915	49,448	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-454,113	-11,538	-442,575	-454,113	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		21,350	240,190	261,540	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet E Part B Date/Time Prepared: 1/30/2018 10:32 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,392	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	54,035,864	2.00
3.00	PPS payments	29,810,998	3.00
4.00	Outlier payment (see instructions)	325,689	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6,392	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	17,975	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)	17,975	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)	17,975	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	11,583	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	6,392	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	30,136,687	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,777,281	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)	24,365,798	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	404,224	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)	24,770,022	30.00
31.00	Primary payer payments	4,739	31.00
32.00	Subtotal (line 30 minus line 31)	24,765,283	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)	293,973	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	191,082	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	220,046	36.00
37.00	Subtotal (see instructions)	24,956,365	37.00
38.00	MSP-LCC reconciliation amount from PS&R	31	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	24,956,334	40.00
40.01	Sequestration adjustment (see instructions)	499,127	40.01
41.00	Interim payments	24,040,444	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	416,763	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	501,477	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: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		145,635		121,812	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		21,872,637		23,869,285	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05		04/13/2017	65,529	04/13/2017	49,347	3.05
3.06		08/31/2017	877,910		0	3.06
	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)		943,439		49,347	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)		22,961,711		24,040,444	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		391,421		416,763	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		23,353,132		24,457,207	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: 14-0130 | Component CCN: 14-5216 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 1/30/2018 10:32 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,964,450		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		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,964,450		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,964,450		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: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet E-1 Part II Date/Time Prepared: 1/30/2018 10:32 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	7,298	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	10,008	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	963	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	22,834	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,245,240,193	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	37,592,404	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	16,000	8.00
9.00	Sequestration adjustment amount (see instructions)	320	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	15,680	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	15,680	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130 Component CCN: 14-5216	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part VI Date/Time Prepared: 1/30/2018 10:32 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	3,440,941	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,440,941	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	415,992	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	3,024,949	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	3,024,949	15.00
15.01	Sequestration adjustment (see instructions)	60,499	15.01
16.00	Interim payments	2,964,450	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 1/30/2018 10:32 am
	Title XIX	Hospital	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	1,936,156		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	1,936,156	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	1,936,156	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	1,936,156	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	1,936,156	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet E-4 | Date/Time Prepared: 1/30/2018 10:32 am

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.			0.00	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)			0.00	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			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			9.56	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	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.	17.03	0.00	17.03	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.	0.00	0.00	0.00	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	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	17.03	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	17.03	0.00		17.00
18.00	Per resident amount	101,986.24	0.00		18.00
19.00	Approved amount for resident costs	1,736,826	0	1,736,826	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)			9.56	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)			1,736,826	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	10,008	963		26.00
27.00	Total Inpatient Days (see instructions)	23,552	23,552		27.00
28.00	Ratio of inpatient days to total inpatient days	0.424932	0.040888		28.00
29.00	Program direct GME amount	738,033	71,015		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		10,034		30.00
31.00	Net Program direct GME amount			799,014	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet E-4 Date/Time Prepared: 1/30/2018 10:32 am
	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)	52,787,205	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)	10,988	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	52,776,217	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	54,042,256	42.00
43.00	Primary payer payments (see instructions)	4,739	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	54,037,517	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	106,813,734	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.494096	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.505904	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	799,014	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	394,790	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	404,224	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G | Date/Time Prepared: 1/30/2018 10:32 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	473,544	23,323,890	26,273,455	0	1.00
2.00	Temporary investments	27,104	0	0	0	2.00
3.00	Notes receivable	-1,373,542	0	0	0	3.00
4.00	Accounts receivable	49,272,212	0	0	0	4.00
5.00	Other receivable	728,585	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-17,502,596	0	0	0	6.00
7.00	Inventory	5,725,499	0	0	0	7.00
8.00	Prepaid expenses	550,654	0	0	0	8.00
9.00	Other current assets	8,208,422	0	0	0	9.00
10.00	Due from other funds	5,021,990	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	51,131,872	23,323,890	26,273,455	0	11.00
	FIXED ASSETS					
12.00	Land	52,023,598	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	184,621,168	0	0	0	15.00
16.00	Accumulated depreciation	-91,345,688	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	60,248,424	0	0	0	19.00
20.00	Accumulated depreciation	-36,064,799	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	169,482,703	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	40,947,664	2,131,409	4,365,128	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	344,507,771	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	385,455,435	2,131,409	4,365,128	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	606,070,010	25,455,299	30,638,583	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	27,206,123	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,930,368	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	37,650,581	0	0	0	43.00
44.00	Other current liabilities	6,971,684	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	81,758,756	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	56,748,700	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	21,418,711	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	78,167,411	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	159,926,167	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	446,143,843				52.00
53.00	Specific purpose fund		25,455,299			53.00
54.00	Donor created - endowment fund balance - restricted			30,638,583		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)	446,143,843	25,455,299	30,638,583	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	606,070,010	25,455,299	30,638,583	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-1 | Date/Time Prepared: 1/30/2018 10:32 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		291,340,476		23,323,890		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,379,575				2.00
3.00	Total (sum of line 1 and line 2)		289,960,901		23,323,890		3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI	4,092,189		0		0	4.00
5.00	YEAR END ADJUSTMENT	13,661,229		0		0	5.00
6.00	POST BENE TO RELATED TO NET PENSION	787,617		0		0	6.00
7.00	GIFTS AND OTHER REVENUE	0		9,693,626		492,557	7.00
8.00	INTERCOMPANY SETTLEMENTS	137,838,464		0		0	8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS	0		1,632,865		3,872,571	9.00
10.00	Total additions (sum of line 4-9)		156,379,499		11,326,491		10.00
11.00	Subtotal (line 3 plus line 10)		446,340,400		34,650,381		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OPERATING EXPENSES	0		1,360,095		0	13.00
14.00	PROPERTY ADDITIONS	0		4,092,189		0	14.00
15.00	RECLASSIFICATION	1		3,676,965		0	15.00
16.00	OTHER	196,556		65,833		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		196,557		9,195,082		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		446,143,843		25,455,299		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	26,273,455		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)	26,273,455		0		3.00
4.00	ASSET RELEA TO FINANCE PROP AND EQUI		0			4.00
5.00	YEAR END ADJUSTMENT		0			5.00
6.00	POST BENE TO RELATED TO NET PENSION		0			6.00
7.00	GIFTS AND OTHER REVENUE		0			7.00
8.00	INTERCOMPANY SETTLEMENTS		0			8.00
9.00	INVESTMENT INCOM & CHG IN NET ASSETS		0			9.00
10.00	Total additions (sum of line 4-9)	4,365,128		0		10.00
11.00	Subtotal (line 3 plus line 10)	30,638,583		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	OPERATING EXPENSES		0			13.00
14.00	PROPERTY ADDITIONS		0			14.00
15.00	RECLASSIFICATION		0			15.00
16.00	OTHER		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)	30,638,583		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 1/30/2018 10:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	66,265,768		66,265,768	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	9,970,908		9,970,908	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	76,236,676		76,236,676	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	12,025,775		12,025,775	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)	12,025,775		12,025,775	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	88,262,451		88,262,451	17.00
18.00	Ancillary services	287,796,204	889,892,345	1,177,688,549	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,052,430	5,052,430	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	376,058,655	894,944,775	1,271,003,430	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		299,561,150		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBT	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)		299,561,150		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0130 | Period: From 09/01/2016 To 08/31/2017 | Worksheet G-3 | Date/Time Prepared: 1/30/2018 10:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,271,003,430	1.00
2.00	Less contractual allowances and discounts on patients' accounts	994,838,388	2.00
3.00	Net patient revenues (line 1 minus line 2)	276,165,042	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	299,561,150	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-23,396,108	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,583,924	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,046,698	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	5,474,525	20.00
21.00	Rental of vending machines	43,297	21.00
22.00	Rental of hospital space	5,210,535	22.00
23.00	Governmental appropriations	6,820	23.00
24.00	NET ASSETS	1,405,712	24.00
24.01	OTHER INCOME	7,245,022	24.01
25.00	Total other income (sum of lines 6-24)	22,016,533	25.00
26.00	Total (line 5 plus line 25)	-1,379,575	26.00
27.00	OTHER	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)	-1,379,575	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0130 HHA CCN: 14-7045

Period: From 09/01/2016 To 08/31/2017

Worksheet H

Date/Time Prepared: 1/30/2018 10:32 am

Home Health Agency I

PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	560,680	0	0	0	0	560,680	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,545,486	0	0	0	0	1,545,486	6.00
7.00	Physical Therapy	631,145	0	0	0	0	631,145	7.00
8.00	Occupational Therapy	146,906	0	0	0	0	146,906	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	41,289	0	0	0	0	41,289	10.00
11.00	Home Health Aide	79,843	0	0	0	0	79,843	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,005,349	0	0	0	0	3,005,349	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	560,680	-122,796	437,884			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,545,486	-338,482	1,207,004			6.00
7.00	Physical Therapy	0	631,145	-138,229	492,916			7.00
8.00	Occupational Therapy	0	146,906	-32,174	114,732			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	41,289	-9,043	32,246			10.00
11.00	Home Health Aide	0	79,843	-17,487	62,356			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	0	3,005,349	-658,211	2,347,138			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0130 | HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-1 Part I | Date/Time Prepared: 1/30/2018 10:32 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	437,884	0	0	0	0	437,884	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,207,004	0	0	0	0	1,207,004	6.00
7.00	Physical Therapy	492,916	0	0	0	0	492,916	7.00
8.00	Occupational Therapy	114,732	0	0	0	0	114,732	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	32,246	0	0	0	0	32,246	10.00
11.00	Home Health Aide	62,356	0	0	0	0	62,356	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,347,138	0	0	0	0	2,347,138	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	437,884			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	272,723	1,479,727		6.00
7.00	Physical Therapy	118,251	611,167		7.00
8.00	Occupational Therapy	24,630	139,362		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	8,220	40,466		10.00
11.00	Home Health Aide	14,060	76,416		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		2,347,138		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-1 Part II Date/Time Prepared: 1/30/2018 10:32 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-437,884	1,512,844	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	-264,776	942,228	6.00
7.00	Physical Therapy	0	0	0	0	-84,370	408,546	7.00
8.00	Occupational Therapy	0	0	0	0	-29,639	85,093	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	-3,845	28,401	10.00
11.00	Home Health Aide	0	0	0	0	-13,780	48,576	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-834,294	1,512,844	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		437,884	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.289444	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0130 HHA CCN: 14-7045

Period: From 09/01/2016 To 08/31/2017

Worksheet H-2 Part I Date/Time Prepared: 1/30/2018 10:32 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	93	0	0	93	2,987	1.00
2.00	Skilled Nursing Care	1,479,727	259	6,394	0	1,486,380	922,542	2.00
3.00	Physical Therapy	611,167	105	0	0	611,272	398,881	3.00
4.00	Occupational Therapy	139,362	24	0	0	139,386	83,080	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	40,466	7	0	0	40,473	27,728	6.00
7.00	Home Health Aide	76,416	13	0	0	76,429	47,427	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	2,347,138	501	6,394	0	2,354,033	1,482,645	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
		7.00	8.00	9.00	10.00	11.00	12.00	
1.00	Administrative and General	1,124	0	0	0	31,686	0	1.00
2.00	Skilled Nursing Care	3,020	0	0	0	87,340	0	2.00
3.00	Physical Therapy	1,265	0	0	0	35,666	0	3.00
4.00	Occupational Therapy	281	0	0	0	8,301	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	70	0	0	0	2,334	0	6.00
7.00	Home Health Aide	141	0	0	0	4,512	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	5,901	0	0	0	169,839	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-2 Part I Date/Time Prepared: 1/30/2018 10:32 am

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV	
		13.00	14.00	15.00	16.00	17.00	21.00	
1.00	Administrative and General	120,623	1,385	0	1,657	0	0	1.00
2.00	Skilled Nursing Care	332,526	3,818	0	4,568	0	0	2.00
3.00	Physical Therapy	135,793	1,559	0	1,865	0	0	3.00
4.00	Occupational Therapy	31,615	363	0	434	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	8,888	102	0	122	0	0	6.00
7.00	Home Health Aide	17,184	197	0	236	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	646,629	7,424	0	8,882	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		22.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	159,555	0	159,555			1.00
2.00	Skilled Nursing Care	0	2,840,194	0	2,840,194	100,350	2,940,544	2.00
3.00	Physical Therapy	0	1,186,301	0	1,186,301	41,916	1,228,217	3.00
4.00	Occupational Therapy	0	263,460	0	263,460	9,309	272,769	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	79,717	0	79,717	2,817	82,534	6.00
7.00	Home Health Aide	0	146,126	0	146,126	5,163	151,289	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	4,675,353	0	4,675,353	159,555	4,675,353	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.035333		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0130 HHA CCN: 14-7045

Period: From 09/01/2016 To 08/31/2017

Worksheet H-2 Part II Date/Time Prepared: 1/30/2018 10:32 am

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	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (DV SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	93	0	544,721	3,678	3,771	16	1.00
2.00	Skilled Nursing Care	257	6,354	1,501,500	-321,851	1,164,529	43	2.00
3.00	Physical Therapy	105	0	613,182	-107,763	503,509	18	3.00
4.00	Occupational Therapy	24	0	142,725	-34,514	104,872	4	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	7	0	40,114	-5,472	35,001	1	6.00
7.00	Home Health Aide	13	0	77,570	-16,562	59,867	2	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	499	6,354	2,919,812		1,871,549	84	20.00
21.00	Total cost to be allocated	501	6,394	0		1,482,645	5,901	21.00
22.00	Unit cost multiplier	1.004008	1.006295	0.000000		0.792202	70.250000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
		8.00	9.00	10.00	11.00	12.00	13.00	
1.00	Administrative and General	0	0	0	13,764	0	6,528	1.00
2.00	Skilled Nursing Care	0	0	0	37,939	0	17,996	2.00
3.00	Physical Therapy	0	0	0	15,493	0	7,349	3.00
4.00	Occupational Therapy	0	0	0	3,606	0	1,711	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	1,014	0	481	6.00
7.00	Home Health Aide	0	0	0	1,960	0	930	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	73,776	0	34,995	20.00
21.00	Total cost to be allocated	0	0	0	169,839	0	646,629	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	2.302090	0.000000	18.477754	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0130 HHA CCN: 14-7045

Period: From 09/01/2016 To 08/31/2017

Worksheet H-2 Part II Date/Time Prepared: 1/30/2018 10:32 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	
		14.00	15.00	16.00	17.00	21.00	22.00	
1.00	Administrative and General	9,479	4,239	942,585	0	0	0	1.00
2.00	Skilled Nursing Care	26,128	11,686	2,598,189	0	0	0	2.00
3.00	Physical Therapy	10,670	4,772	1,061,047	0	0	0	3.00
4.00	Occupational Therapy	2,484	1,111	246,970	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	698	312	69,412	0	0	0	6.00
7.00	Home Health Aide	1,350	604	134,227	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	50,809	22,724	5,052,430	0	0	0	20.00
21.00	Total cost to be allocated	7,424	0	8,882	0	0	0	21.00
22.00	Unit cost multiplier	0.146116	0.000000	0.001758	0.000000	0.000000	0.000000	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 1/30/2018 10:32 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	2,940,544		2,940,544	4,836	608.05	1.00
2.00	Physical Therapy	3.00	1,228,217	0	1,228,217	3,275	375.03	2.00
3.00	Occupational Therapy	4.00	272,769	0	272,769	780	349.70	3.00
4.00	Speech Pathology	5.00	0	0	0	0	0.00	4.00
5.00	Medical Social Services	6.00	82,534		82,534	153	539.44	5.00
6.00	Home Health Aide	7.00	151,289		151,289	597	253.42	6.00
7.00	Total (sum of lines 1-6)		4,675,353	0	4,675,353	9,641		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	630			8.00
8.01	Skilled Nursing Care		29404	0	4,206			8.01
9.00	Physical Therapy		16974	0	427			9.00
9.01	Physical Therapy		29404	0	2,848			9.01
10.00	Occupational Therapy		16974	0	69			10.00
10.01	Occupational Therapy		29404	0	711			10.01
11.00	Speech Pathology		16974	0	0			11.00
11.01	Speech Pathology		29404	0	0			11.01
12.00	Medical Social Services		16974	0	5			12.00
12.01	Medical Social Services		29404	0	148			12.01
13.00	Home Health Aide		16974	0	47			13.00
13.01	Home Health Aide		29404	0	550			13.01
14.00	Total (sum of lines 8-13)			0	9,641			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,836		0	2,940,530		1.00
2.00	Physical Therapy	0	3,275		0	1,228,223		2.00
3.00	Occupational Therapy	0	780		0	272,766		3.00
4.00	Speech Pathology	0	0		0	0		4.00
5.00	Medical Social Services	0	153		0	82,534		5.00
6.00	Home Health Aide	0	597		0	151,292		6.00
7.00	Total (sum of lines 1-6)	0	9,641		0	4,675,345		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-3 Part I Date/Time Prepared: 1/30/2018 10:32 am

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)		
		12.00		
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION			
	Cost Per Visit Computation			
1.00	Skilled Nursing Care	2,940,530		1.00
2.00	Physical Therapy	1,228,223		2.00
3.00	Occupational Therapy	272,766		3.00
4.00	Speech Pathology	0		4.00
5.00	Medical Social Services	82,534		5.00
6.00	Home Health Aide	151,292		6.00
7.00	Total (sum of lines 1-6)	4,675,345		7.00

	Cost Center Description			
		12.00		
	Limitation Cost Computation			
8.00	Skilled Nursing Care			8.00
8.01	Skilled Nursing Care			8.01
9.00	Physical Therapy			9.00
9.01	Physical Therapy			9.01
10.00	Occupational Therapy			10.00
10.01	Occupational Therapy			10.01
11.00	Speech Pathology			11.00
11.01	Speech Pathology			11.01
12.00	Medical Social Services			12.00
12.01	Medical Social Services			12.01
13.00	Home Health Aide			13.00
13.01	Home Health Aide			13.01
14.00	Total (sum of lines 8-13)			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0130 HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-3 Part II Date/Time Prepared: 1/30/2018 10:32 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.357907	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology	68.00	0.649666	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.219535	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.388833	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0130 | HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 1/30/2018 10:32 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,584,508	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	119,196	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	40,608	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	30,748	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	18,785	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,793,845	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,793,845	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,793,845	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,793,845	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	1,793,845	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
32.00	Interim payments (see instructions)	0	1,793,845	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0130 | HHA CCN: 14-7045 | Period: From 09/01/2016 To 08/31/2017 | Worksheet H-5 | Date/Time Prepared: 1/30/2018 10:32 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,793,845	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,793,845	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,793,845	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0130	Period: From 09/01/2016 To 08/31/2017	Worksheet L Parts I-III Date/Time Prepared: 1/30/2018 10:32 am
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,808,309	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	51,503	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)	65.47	3.00
4.00	Number of interns & residents (see instructions)	17.03	4.00
5.00	Indirect medical education percentage (see instructions)	7.62	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)	137,793	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	11.20	8.00
9.00	Sum of lines 7 and 8	14.04	9.00
10.00	Allowable disproportionate share percentage (see instructions)	2.88	10.00
11.00	Disproportionate share adjustment (see instructions)	52,079	11.00
12.00	Total prospective capital payments (see instructions)	2,049,684	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