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: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/23/2018 11:16 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2018 Time: 11:16 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. MARGARET'S HOSPITAL (14-0143) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	106,108	-123,130	0	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
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	106,108	-123,130	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2018 7:38 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 EAST FIRST ST	PO Box:			1.00
2.00	City: SPRING VALLEY	State: IL	Zip Code: 61362	County: BUREAU	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	ST. MARGARET'S HOSPITAL	140143	99914	1	07/01/1966	N	P	P	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	ST. MARGARET'S HOSPITAL	14U143	99914		06/23/2003	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	ST. MARGARET'S HOSPITAL	141595	99914		07/07/1998				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)	10/01/2016	09/30/2017	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	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.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,487	0	0	0	4	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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2018 7:38 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	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.	1		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.	10/01/2016	09/30/2017	38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 7:38 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2018 7:38 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/23/2018 7:38 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 7:38 am

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	424,412	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	35HO02	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 7:38 am

		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: SISTERS MARY OF THE PRESENTATION HC		Contractor's Name: NORIDIAN ADMIN SVC	Contractor's Number: 03001	141.00
142.00	Street: 1202 PAGE DR SW PO BOX 10007		PO Box:		142.00
143.00	City: FARGO		State: ND	Zip Code: 58106-0007	143.00

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

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

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

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

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

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

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

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

		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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2018 7:38 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	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	02/02/2017	Y	02/02/2017 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.	Y		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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2018 7:38 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:	PIP PYMTS WERE ENTERED AS PAYMENT.		Y	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.	DON	TROGLIO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. MARGARET'S HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-664-1328	DTROGLIO@ABOUTSMG.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/23/2018 7:38 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF ACCOUNTING		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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2018 7:38 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	50	18,250	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)		50	18,250	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	6	2,190	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)		56	20,440	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		56				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2018 7:38 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)	3,218	911	5,470			1.00
2.00	HMO and other (see instructions)	710	4				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	31	0	31			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)	3,249	911	5,501			7.00
8.00	INTENSIVE CARE UNIT	532	57	836			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		462	678			13.00
14.00	Total (see instructions)	3,781	1,430	7,015	0.00	582.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	8.56	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	591.07	27.00
28.00	Observation Bed Days		486	2,678			28.00
29.00	Ambulance Trips	558					29.00
30.00	Employee discount days (see instruction)			19			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	57	113			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2018 7:38 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	987	608	1,913	1.00
2.00	HMO and other (see instructions)			149	2		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	987	608	1,913	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2018 7:38 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	35,572,594	764,956	36,337,550	1,225,086.86	29.66	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	7,392	7,392	54.00	136.89	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		8,216,161	757,564	8,973,725	50,142.50	178.96	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,130,180	125,946	1,256,126	54,663.01	22.98	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		609,685	0	609,685	8,745.30	69.72	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		1,110,020	0	1,110,020	4,850.76	228.83	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		1,042,774	0	1,042,774	7,578.00	137.61	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)		5,610,521	0	5,610,521			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		234,981	0	234,981			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		242,302	0	242,302			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		243,003	0	243,003			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	193,745	0	193,745	7,337.75	26.40	26.00
27.00	Administrative & General	5.00	3,022,944	-125,946	2,896,998	124,187.19	23.33	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2018 7:38 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		201,038	0	201,038	739.77	271.76	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	473,196	0	473,196	22,166.75	21.35	30.00
31.00	Laundry & Linen Service	8.00	0	41,105	41,105	3,378.00	12.17	31.00
32.00	Housekeeping	9.00	530,540	-41,105	489,435	38,131.53	12.84	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	793,368	-581,063	212,305	14,285.07	14.86	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	581,063	581,063	39,097.12	14.86	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,078,101	0	1,078,101	28,358.98	38.02	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,575,326	0	1,575,326	55,857.13	28.20	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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/23/2018 7:38 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)		27,557,471	7,392	27,564,863	1,175,684.13	23.45	1.00
2.00	Excluded area salaries (see instructions)		1,130,180	125,946	1,256,126	54,663.01	22.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)		26,427,291	-118,554	26,308,737	1,121,021.12	23.47	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,762,479	0	2,762,479	21,174.06	130.47	4.00
5.00	Subtotal wage-related costs (see inst.)		5,853,524	0	5,853,524	0.00	22.25	5.00
6.00	Total (sum of lines 3 thru 5)		35,043,294	-118,554	34,924,740	1,142,195.18	30.58	6.00
7.00	Total overhead cost (see instructions)		7,868,258	-125,946	7,742,312	333,539.29	23.21	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/23/2018 7:38 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	780,620	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)	0	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)	2,357,876	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	197,249	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	36,369	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	3,563	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	232,874	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	147,660	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	1,776,442	17.00
18.00	Medicare Taxes - Employers Portion Only	512,366	18.00
19.00	Unemployment Insurance	21,829	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	20,957	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	6,087,805	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 2/23/2018 7:38 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	609,685	6,087,805	1.00
2.00	Hospital	609,685	6,087,805	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet S-7 Date/Time Prepared: 2/23/2018 7:38 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.	Y		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.	Y	06/23/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	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	13	13	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	2	2	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	5	5	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	7	7	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	4	4	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 | Date/Time Prepared: 2/23/2018 7:38 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	31	31	200.00

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

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

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	5,921	0	0	5,921	11.00
12.00	Hospice Inpatient Respite Care	5	0	0	5	12.00
13.00	Hospice General Inpatient Care	97	0	0	97	13.00
14.00	Total Hospice Days	6,023	0	0	6,023	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/23/2018 7:38 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)	0.312907	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,920,538	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	32,575,256	6.00
7.00	Medicaid cost (line 1 times line 6)	10,193,026	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)	6,272,488	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	4,858	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,272,488	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)	669,985	2,848,528	3,518,513	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	209,643	2,848,528	3,058,171	21.00
22.00	Payments received from patients for amounts previously written off as charity care	48,638	766,792	815,430	22.00
23.00	Cost of charity care (line 21 minus line 22)	161,005	2,081,736	2,242,741	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,802,123	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	246,627	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	379,426	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	1,422,697	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	577,971	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,820,712	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,093,200	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/23/2018 7:38 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	NEW CAP REL COSTS-BLDG & FIXT		3,136,778	3,136,778	-178,581	2,958,197	1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT		47,392	47,392	0	47,392	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		2,643,652	2,643,652	132,264	2,775,916	2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	193,745	6,163,898	6,357,643	0	6,357,643	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,022,944	6,276,607	9,299,551	-126,805	9,172,746	5.00
7.00	00700	OPERATION OF PLANT	473,196	1,514,123	1,987,319	0	1,987,319	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	156,902	156,902	41,105	198,007	8.00
9.00	00900	HOUSEKEEPING	530,540	236,785	767,325	-41,105	726,220	9.00
10.00	01000	DIETARY	793,368	407,028	1,200,396	-879,186	321,210	10.00
11.00	01100	CAFETERIA	0	0	0	879,186	879,186	11.00
13.00	01300	NURSING ADMINISTRATION	1,078,101	67,988	1,146,089	0	1,146,089	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,575,326	376,630	1,951,956	0	1,951,956	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,692,787	1,543,879	4,236,666	-100,696	4,135,970	30.00
31.00	03100	INTENSIVE CARE UNIT	713,271	103,962	817,233	0	817,233	31.00
43.00	04300	NURSERY	55,991	242,244	298,235	0	298,235	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,046,857	3,567,334	5,614,191	0	5,614,191	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	299,135	54,144	353,279	100,696	453,975	52.00
53.00	05300	ANESTHESIOLOGY	0	1,628,035	1,628,035	0	1,628,035	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	841,368	1,237,147	2,078,515	0	2,078,515	54.00
54.01	05402	NUCLEAR MEDICINE	124,028	398,171	522,199	0	522,199	54.01
57.00	05700	CT SCAN	152,537	227,791	380,328	0	380,328	57.00
60.00	06000	LABORATORY	992,941	2,002,035	2,994,976	0	2,994,976	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	203,172	203,172	0	203,172	63.00
65.00	06500	RESPIRATORY THERAPY	410,350	155,000	565,350	0	565,350	65.00
66.00	06600	PHYSICAL THERAPY	1,265,129	123,875	1,389,004	0	1,389,004	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,176	9,003	165,179	0	165,179	67.00
68.00	06800	SPEECH PATHOLOGY	77,812	4,147	81,959	0	81,959	68.00
69.00	06900	ELECTROCARDIOLOGY	105,338	101,822	207,160	0	207,160	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61,730	34,763	96,493	0	96,493	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,485	230,810	273,295	0	273,295	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,579,503	2,579,503	0	2,579,503	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	770,383	2,026,324	2,796,707	0	2,796,707	73.00
76.00	03020	SONOGRAPHY	181,173	324,265	505,438	0	505,438	76.00
76.01	03040	AUDIOLOGY	0	0	0	274,350	274,350	76.01
76.02	03160	CARDIAC REHAB	172,004	13,764	185,768	0	185,768	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	14,728,995	3,673,613	18,402,608	769,211	19,171,819	90.00
91.00	09100	EMERGENCY	884,704	1,985,764	2,870,468	0	2,870,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	798,943	798,943	0	798,943	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,061,749	1,061,749	-1,061,749	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
116.00	11600	HOSPICE	508,780	541,383	1,050,163	0	1,050,163	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,951,194	45,900,425	80,851,619	-191,310	80,660,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	33,643	3,588	37,231	0	37,231	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	48,446	16,897	65,343	0	65,343	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	92	2,281	2,373	0	2,373	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	234,201	323,981	558,182	0	558,182	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/23/2018 7:38 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	
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	177,542	177,542	194.20
194.21	07971	OCCUPATIONAL HEALTH	206,726	32,014	238,740	13,768	252,508	194.21
194.24	07974	SURGICAL ASSOCIATES	0	238	238	0	238	194.24
194.27	07977	MIDTOWN	0	0	0	0	0	194.27
194.28	07978	PAIN CLINIC	98,292	3,927	102,219	0	102,219	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	35,572,594	46,283,351	81,855,945	0	81,855,945	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-119,653	2,838,544		1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	47,392		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	641	2,776,557		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	88	88		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-938,171	5,419,472		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-416,349	8,756,397		5.00
7.00	00700	OPERATION OF PLANT	-1,800	1,985,519		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	198,007		8.00
9.00	00900	HOUSEKEEPING	0	726,220		9.00
10.00	01000	DIETARY	0	321,210		10.00
11.00	01100	CAFETERIA	-205,077	674,109		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,146,089		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,468	1,950,488		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-884,027	3,251,943		30.00
31.00	03100	INTENSIVE CARE UNIT	-14,100	803,133		31.00
43.00	04300	NURSERY	-219,108	79,127		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,614,191		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	453,975		52.00
53.00	05300	ANESTHESIOLOGY	-1,384,253	243,782		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,078,515		54.00
54.01	05402	NUCLEAR MEDICINE	0	522,199		54.01
57.00	05700	CT SCAN	0	380,328		57.00
60.00	06000	LABORATORY	0	2,994,976		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	203,172		63.00
65.00	06500	RESPIRATORY THERAPY	0	565,350		65.00
66.00	06600	PHYSICAL THERAPY	-2,970	1,386,034		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	165,179		67.00
68.00	06800	SPEECH PATHOLOGY	0	81,959		68.00
69.00	06900	ELECTROCARDIOLOGY	-21,600	185,560		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	96,493		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	273,295		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,579,503		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-265,118	2,531,589		73.00
76.00	03020	SONOGRAPHY	0	505,438		76.00
76.01	03040	AUDIOLOGY	0	274,350		76.01
76.02	03160	CARDIAC REHAB	0	185,768		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	-8,396,833	10,774,986		90.00
91.00	09100	EMERGENCY	-1,399,608	1,470,860		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	798,943		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
116.00	11600	HOSPICE	0	1,050,163		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,269,406	66,390,903		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0		194.00
194.01	07951	CONGREGATE LIVING	0	37,231		194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0		194.02
194.03	07953	MANAGED CARE	0	65,343		194.03
194.04	07954	RENTAL AREA/PPOS	0	0		194.04
194.05	07955	SPECIALTY CLINICS	0	2,373		194.05
194.08	07958	ENT	0	0		194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	558,182		194.09
194.10	07960	PERU MALL	0	0		194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0		194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0		194.13
194.14	07964	HENRY	0	0		194.14
194.16	07966	SPRING VALLEY CLINIC	0	0		194.16
194.17	07967	OGLESBY MP OB	0	0		194.17
194.18	07968	FAMILY HEALTH CENTER	0	0		194.18
194.19	07969	GRANVILLE CLINIC	0	0		194.19
194.20	07970	PARATRANSIT	0	177,542		194.20

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.21	07971	OCCUPATIONAL HEALTH	0	252,508		194.21
194.24	07974	SURGICAL ASSOCIATES	0	238		194.24
194.27	07977	MIDTOWN	0	0		194.27
194.28	07978	PAIN CLINIC	0	102,219		194.28
194.30	07980	WHC-PTON	0	0		194.30
194.31	07981	CFH	0	0		194.31
194.32	07982	PFS	0	0		194.32
200.00		TOTAL (SUM OF LINES 118 through 199)	-14,269,406	67,586,539		200.00

RECLASSIFICATIONS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/23/2018 7:38 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - IV COSTS FROM PHARMACY				
1.00		0.00	0	0	1.00
	TOTALS		0	0	
	B - DIETARY RECLASS				
1.00	CAFETERIA	11.00	581,063	298,123	1.00
	TOTALS		581,063	298,123	
	C - LAUNDRY SALARIES				
1.00	LAUNDRY & LINEN SERVICE	8.00	41,105	0	1.00
	TOTALS		41,105	0	
	D - DEPRECIATION FOR OFF CAMPUS CLINICS				
1.00	CLINIC	90.00	0	1,043,561	1.00
2.00	OCCUPATIONAL HEALTH	194.21	0	13,768	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	1,057,329	
	E - AUDIOLOGY COSTS				
1.00	AUDIOLOGY	76.01	0	274,350	1.00
	TOTALS		0	274,350	
	F - INTEREST EXPENSE ON EQUIPMENT				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	132,264	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	50,737	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	878,748	3.00
	TOTALS		0	1,061,749	
	G - PARATRANSIT COSTS				
1.00	PARATRANSIT	194.20	125,946	51,596	1.00
	TOTALS		125,946	51,596	
	H - LABOR AND DELIVERY SALARIES				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	100,696	0	1.00
	TOTALS		100,696	0	
	I - TO RECLASS EMPLOYED HOSPITALIST				
1.00	ADULTS & PEDIATRICS	30.00	764,956	0	1.00
	TOTALS		764,956	0	
500.00	Grand Total: Increases		1,613,766	2,743,147	500.00

RECLASSIFICATIONS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/23/2018 7:38 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - IV COSTS FROM PHARMACY						
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
	B - DIETARY RECLASS						
1.00	DIETARY	10.00	581,063	298,123	0		1.00
	TOTALS		581,063	298,123			
	C - LAUNDRY SALARIES						
1.00	HOUSEKEEPING	9.00	41,105	0	0		1.00
	TOTALS		41,105	0			
	D - DEPRECIATION FOR OFF CAMPUS CLINICS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,057,329	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,057,329			
	E - AUDIOLOGY COSTS						
1.00	CLINIC	90.00	0	274,350	0		1.00
	TOTALS		0	274,350			
	F - INTEREST EXPENSE ON EQUIPMENT						
1.00	INTEREST EXPENSE	113.00	0	1,061,749	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	1,061,749			
	G - PARATRANSIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	125,946	51,596	0		1.00
	TOTALS		125,946	51,596			
	H - LABOR AND DELIVERY SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	100,696	0	0		1.00
	TOTALS		100,696	0			
	I - TO RECLASS EMPLOYED HOSPITALIST						
1.00	ADULTS & PEDIATRICS	30.00	0	764,956	0		1.00
	TOTALS		0	764,956			
500.00	Grand Total: Decreases		848,810	3,508,103			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2018 7:38 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,762,328	0	0	0	71,067	1.00
2.00	Land Improvements	2,749,678	212,025	0	212,025	22,710	2.00
3.00	Buildings and Fixtures	69,436,753	4,016,615	0	4,016,615	4,456,651	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	27,436,037	3,584,954	0	3,584,954	1,341,236	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	102,384,796	7,813,594	0	7,813,594	5,891,664	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	102,384,796	7,813,594	0	7,813,594	5,891,664	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,691,261	0	1.00
2.00	Land Improvements	2,938,993	0	2.00
3.00	Buildings and Fixtures	68,996,717	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	29,679,755	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	104,306,726	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	104,306,726	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2018 7:38 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	NEW CAP REL COSTS-BLDG & FIXT	3,136,778	0	0	0	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	47,392	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2,643,652	0	0	0	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	5,827,822	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	3,136,778		1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	47,392		1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,643,652		2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0		2.01
3.00	Total (sum of lines 1-2)	0	5,827,822		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2018 7:38 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	73,543,676	0	73,543,676	0.705071	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	1,083,295	0	1,083,295	0.010386	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	29,669,076	0	29,669,076	0.284441	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	10,679	0	10,679	0.000102	0	2.01
3.00	Total (sum of lines 1-2)	104,306,726	0	104,306,726	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	2,079,449	0	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	47,392	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	2,644,293	0	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	88	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	4,771,222	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	759,095	0	0	0	2,838,544	1.00
1.01	OLD CAP REL COSTS-BLDG & FIXT	0	0	0	0	47,392	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	132,264	0	0	0	2,776,557	2.00
2.01	OLD CAP REL COSTS-MVBLE EQUIP	0	0	0	0	88	2.01
3.00	Total (sum of lines 1-2)	891,359	0	0	0	5,662,581	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/23/2018 7:38 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-104,720	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - OLD CAP REL COSTS-BLDG & FIXT (chapter 2)		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - OLD CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	2.01
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)	B	-6,740	ADMINISTRATIVE & GENERAL	5.00	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)	A	-1,800	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-12,522,035			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	-38,876			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-205,077	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-265,118	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,468	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - OLD CAP REL COSTS-BLDG & FIXT		0	OLD CAP REL COSTS-BLDG & FIXT	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - OLD CAP REL COSTS-MVBLE EQUIP		0	OLD CAP REL COSTS-MVBLE EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/23/2018 7:38 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	
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.00
33.01	OUTSIDE PHYSICAL THERAPY	B	-2,970	PHYSICAL THERAPY	66.00	0	33.01
33.03	OB COMISSIONS	B	-22	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	HOME OFFICE OPERATING INTEREST INCOM	B	-14,933	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.06	PATIENT PHONES	A	-29,799	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PATIENT PHONES DEPRECIATION	A	-10,698	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	33.07
33.10	MISC INCOME	B	-2,148	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PHYSICIAN RECRUITMENT	A	-265,172	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	EMPLOYEE HEALTH	A	-695,869	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.13	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.13
33.15	ADMIN COSTS FOR POB	A	164	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.16
33.17	LOBBYING PORTION OF IHHA DUES	A	-30,861	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.18
34.00	MISC REVENUE	B	-15,000	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	HOSPITALIST RECEPTIONIST & OTHER EXP	A	-39,796	ADULTS & PEDIATRICS	30.00	0	35.00
36.00	LEADERSHIP CONFERENCE SPOUSE COSTS	A	-16,468	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	37.00
38.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	38.00
39.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	41.00
42.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.00
43.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,269,406				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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2018 7:38 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	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	1,435,385	1,481,688	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	SISTERS SALARIES	0	4,000	2.00
3.00	2.01	OLD CAP REL COSTS-MVBLE EQUI	OLD CAPITAL COSTS	88	0	3.00
4.00	2.00	NEW CAP REL COSTS-MVBLE EQUI	NEW CAPITAL COSTS	11,339	0	4.00
5.00	0		0	1,446,812	1,485,688	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	SRS OF MARY OF THE PRES	100.00	6.00
7.00	G	SMP HEALTH CORP	0.00	SMP HEALTH CORP	0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	NON-FINANCIAL				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: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/23/2018 7:38 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	-46,303	0		1.00
2.00	-4,000	0		2.00
3.00	88	9		3.00
4.00	11,339	9		4.00
5.00	-38,876			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	RELIGIOUS COMMUNITY		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2018 7:38 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESIOLOGY	1,429,025	1,161,529	267,496	239,400	389	1.00
2.00	91.00	EMERGENCY	1,707,264	1,010,530	696,734	179,000	3,575	2.00
3.00	43.00	NURSERY	219,108	219,108	0	0	0	3.00
4.00	60.00	LABORATORY	35,000	0	35,000	260,300	520	4.00
5.00	69.00	ELECTROCARDIOLOGY	21,600	21,600	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	14,100	14,100	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	784,644	777,252	7,392	211,500	54	7.00
8.00	30.00	ADULTS & PEDIATRICS	132,290	0	132,290	211,500	661	8.00
9.00	90.00	CLINIC	8,216,161	8,216,161	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	242,302	242,302	0	0	0	10.00
11.00	90.00	CLINIC	31,500	31,500	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	13,500	0	13,500	211,500	225	12.00
13.00	90.00	CLINIC	149,172	149,172	0	0	0	13.00
200.00			12,995,666	11,843,254	1,152,412		5,424	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESIOLOGY	44,772	2,239	0	0	0	1.00
2.00	91.00	EMERGENCY	307,656	15,383	0	0	0	2.00
3.00	43.00	NURSERY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	65,075	3,254	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	5,491	275	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	67,212	3,361	0	0	0	8.00
9.00	90.00	CLINIC	0	0	0	0	0	9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	22,879	1,144	0	0	0	12.00
13.00	90.00	CLINIC	0	0	0	0	0	13.00
200.00			513,085	25,656	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	53.00	ANESTHESIOLOGY	0	44,772	222,724	1,384,253		1.00
2.00	91.00	EMERGENCY	0	307,656	389,078	1,399,608		2.00
3.00	43.00	NURSERY	0	0	0	219,108		3.00
4.00	60.00	LABORATORY	0	65,075	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	21,600		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	0	0	14,100		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	5,491	1,901	779,153		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	67,212	65,078	65,078		8.00
9.00	90.00	CLINIC	0	0	0	8,216,161		9.00
10.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	242,302		10.00
11.00	90.00	CLINIC	0	0	0	31,500		11.00
12.00	16.00	MEDICAL RECORDS & LIBRARY	0	22,879	0	0		12.00
13.00	90.00	CLINIC	0	0	0	149,172		13.00
200.00			0	513,085	678,781	12,522,035		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	2,838,544	2,838,544				1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	47,392	0	47,392			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	2,776,557			2,776,557		2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP	88			0	88	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,419,472	9,910	165	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,756,397	991,961	16,562	993,281	88	5.00
7.00	00700	OPERATION OF PLANT	1,985,519	268,840	4,489	35,192	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	198,007	7,115	119	0	0	8.00
9.00	00900	HOUSEKEEPING	726,220	28,396	474	11,316	0	9.00
10.00	01000	DIETARY	321,210	70,626	1,179	24,337	0	10.00
11.00	01100	CAFETERIA	674,109	24,283	405	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,146,089	24,372	407	3,566	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,950,488	37,589	628	28,434	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,251,943	209,029	3,490	153,683	0	30.00
31.00	03100	INTENSIVE CARE UNIT	803,133	45,653	762	16,667	0	31.00
43.00	04300	NURSERY	79,127	10,941	183	40,686	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,614,191	246,224	4,111	321,666	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	453,975	5,511	92	17,015	0	52.00
53.00	05300	ANESTHESIOLOGY	243,782	4,131	69	11,045	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,078,515	71,818	1,199	292,867	0	54.00
54.01	05402	NUCLEAR MEDICINE	522,199	18,799	314	91,954	0	54.01
57.00	05700	CT SCAN	380,328	5,824	97	158,357	0	57.00
60.00	06000	LABORATORY	2,994,976	35,026	585	40,681	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	203,172	2,097	35	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	565,350	13,978	233	22,812	0	65.00
66.00	06600	PHYSICAL THERAPY	1,386,034	93,699	1,564	572	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	165,179	349	6	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	81,959	1,577	26	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	185,560	1,183	20	11,776	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	96,493	11,935	199	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	273,295	66,271	1,106	19,667	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,579,503	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,531,589	25,627	428	16,569	0	73.00
76.00	03020	SONOGRAPHY	505,438	4,794	80	42,874	0	76.00
76.01	03040	AUDIOLOGY	274,350	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	185,768	13,360	223	6,644	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	10,774,986	151,969	2,537	276,104	0	90.00
91.00	09100	EMERGENCY	1,470,860	87,839	1,467	127,058	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	798,943	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,050,163	8,727	146	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,390,903	2,599,453	43,400	2,764,823	88	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,962	200	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	37,231	118,941	1,986	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	65,343	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	82,203	1,372	0	0	194.04
194.05	07955	SPECIALTY CLINICS	2,373	0	0	1,998	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	558,182	25,985	434	4,597	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	177,542	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	252,508	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	238	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	5,139	0	194.27
194.28	07978	PAIN CLINIC	102,219	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	67,586,539	2,838,544	47,392	2,776,557	88	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,429,547					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	563,857	11,322,146	11,322,146			5.00
7.00	00700	OPERATION OF PLANT	92,101	2,386,141	480,166	2,866,307		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,000	213,241	42,911	13,007	269,159	8.00
9.00	00900	HOUSEKEEPING	95,261	861,667	173,394	51,913	0	9.00
10.00	01000	DIETARY	41,322	458,674	92,299	129,118	0	10.00
11.00	01100	CAFETERIA	113,095	811,892	163,378	44,394	0	11.00
13.00	01300	NURSING ADMINISTRATION	209,836	1,384,270	278,558	44,557	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	306,614	2,323,753	467,611	68,720	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	647,239	4,265,384	858,327	382,146	175,042	30.00
31.00	03100	INTENSIVE CARE UNIT	138,828	1,005,043	202,246	83,463	14,346	31.00
43.00	04300	NURSERY	10,898	141,835	28,542	20,002	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	398,390	6,584,582	1,325,022	450,145	28,531	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,821	554,414	111,565	10,075	0	52.00
53.00	05300	ANESTHESIOLOGY	0	259,027	52,124	7,552	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	163,760	2,608,159	524,842	131,297	17,953	54.00
54.01	05402	NUCLEAR MEDICINE	24,140	657,406	132,290	34,368	0	54.01
57.00	05700	CT SCAN	29,689	574,295	115,566	10,648	3,580	57.00
60.00	06000	LABORATORY	193,261	3,264,529	656,924	64,035	135	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	205,304	41,314	3,833	0	63.00
65.00	06500	RESPIRATORY THERAPY	79,868	682,241	137,288	25,555	525	65.00
66.00	06600	PHYSICAL THERAPY	246,238	1,728,107	347,749	171,301	14,346	66.00
67.00	06700	OCCUPATIONAL THERAPY	30,397	195,931	39,427	639	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,145	98,707	19,863	2,883	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,502	219,041	44,078	2,162	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,015	120,642	24,277	21,820	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,269	368,608	74,175	121,157	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,579,503	519,076	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	149,943	2,724,156	548,185	46,851	0	73.00
76.00	03020	SONOGRAPHY	35,263	588,449	118,414	8,764	0	76.00
76.01	03040	AUDIOLOGY	0	274,350	55,208	0	0	76.01
76.02	03160	CARDIAC REHAB	33,478	239,473	48,189	24,425	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	1,267,638	12,473,234	2,510,009	277,829	0	90.00
91.00	09100	EMERGENCY	172,194	1,859,418	374,173	160,587	14,346	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	798,943	160,772	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	99,026	1,158,062	233,038	15,956	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,284,088	65,990,627	11,001,000	2,429,202	268,804	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,162	2,447	21,869	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	6,548	164,706	33,144	217,447	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	9,429	74,772	15,046	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	83,575	16,818	150,283	0	194.04
194.05	07955	SPECIALTY CLINICS	18	4,389	883	0	355	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	45,584	634,782	127,738	47,506	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	24,513	202,055	40,660	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	40,236	292,744	58,909	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	238	48	0	0	194.24
194.27	07977	MIDTOWN	0	5,139	1,034	0	0	194.27
194.28	07978	PAIN CLINIC	19,131	121,350	24,419	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,429,547	67,586,539	11,322,146	2,866,307	269,159	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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	1,086,974					9.00
10.00	01000	DIETARY	53,967	734,058				10.00
11.00	01100	CAFETERIA	43,046	0	1,062,710			11.00
13.00	01300	NURSING ADMINISTRATION	32,364	0	46,257	1,786,006		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,416	0	139,091	0	3,064,591	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	415,339	493,110	211,662	766,245	168,278	30.00
31.00	03100	INTENSIVE CARE UNIT	53,517	98,176	44,855	162,339	23,831	31.00
43.00	04300	NURSERY	4,918	0	7,249	26,285	9,769	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,516	31	150,305	544,182	469,817	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,708	0	21,787	78,925	16,213	52.00
53.00	05300	ANESTHESIOLOGY	899	0	0	0	85,524	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,153	0	63,999	0	202,392	54.00
54.01	05402	NUCLEAR MEDICINE	1,957	0	9,372	0	38,818	54.01
57.00	05700	CT SCAN	1,957	0	6,047	0	227,878	57.00
60.00	06000	LABORATORY	21,655	0	85,145	0	470,529	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,274	0	0	0	5,239	63.00
65.00	06500	RESPIRATORY THERAPY	5,235	0	26,152	0	48,043	65.00
66.00	06600	PHYSICAL THERAPY	10,788	0	0	0	117,926	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	13,922	67.00
68.00	06800	SPEECH PATHOLOGY	1,957	0	0	0	5,020	68.00
69.00	06900	ELECTROCARDIOLOGY	3,384	0	6,848	0	68,159	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	767	0	5,807	0	16,739	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,235	0	5,807	0	144,999	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	57,184	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,655	0	38,568	0	97,920	73.00
76.00	03020	SONOGRAPHY	1,957	0	9,772	0	93,389	76.00
76.01	03040	AUDIOLOGY	1,957	0	0	0	7,120	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	13,588	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	75,093	0	93,496	90.00
91.00	09100	EMERGENCY	21,655	0	57,471	208,030	134,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	10,233	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	34,282	0	42,530	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	912,276	591,317	1,045,569	1,786,006	2,683,000	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,957	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	97,146	194.00
194.01	07951	CONGREGATE LIVING	0	142,741	3,564	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	41,737	194.02
194.03	07953	MANAGED CARE	0	0	3,324	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	172,741	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	5,121	194.05
194.08	07958	ENT	0	0	0	0	25,192	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	8,261	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	47,253	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	43,238	194.13
194.14	07964	HENRY	0	0	0	0	1,403	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	1,581	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	1,722	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	32,662	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	5,930	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
194.21	07971	OCCUPATIONAL HEALTH	0	0	10,253	0	5,426	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	40,371	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	830	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	22,978	194.31
194.32	07982	PFS	0	0	0	0	740	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,086,974	734,058	1,062,710	1,786,006	3,064,591	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	7,735,533	0	7,735,533		30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,687,816	0	1,687,816		31.00
43.00	04300	NURSERY	0	238,600	0	238,600		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,639,131	0	9,639,131		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	814,687	0	814,687		52.00
53.00	05300	ANESTHESIOLOGY	0	405,126	0	405,126		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,580,795	0	3,580,795		54.00
54.01	05402	NUCLEAR MEDICINE	0	874,211	0	874,211		54.01
57.00	05700	CT SCAN	0	939,971	0	939,971		57.00
60.00	06000	LABORATORY	0	4,562,952	0	4,562,952		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	257,964	0	257,964		63.00
65.00	06500	RESPIRATORY THERAPY	0	925,039	0	925,039		65.00
66.00	06600	PHYSICAL THERAPY	0	2,390,217	0	2,390,217		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	249,919	0	249,919		67.00
68.00	06800	SPEECH PATHOLOGY	0	128,430	0	128,430		68.00
69.00	06900	ELECTROCARDIOLOGY	0	343,672	0	343,672		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	190,052	0	190,052		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	719,981	0	719,981		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,155,763	0	3,155,763		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,477,335	0	3,477,335		73.00
76.00	03020	SONOGRAPHY	0	820,745	0	820,745		76.00
76.01	03040	AUDIOLOGY	0	338,635	0	338,635		76.01
76.02	03160	CARDIAC REHAB	0	325,675	0	325,675		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	15,429,661	0	15,429,661		90.00
91.00	09100	EMERGENCY	0	2,830,124	0	2,830,124		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	969,948	0	969,948		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,483,868	0	1,483,868		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	64,515,850	0	64,515,850		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38,435	0	38,435		190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	97,146	0	97,146		194.00
194.01	07951	CONGREGATE LIVING	0	561,602	0	561,602		194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	41,737	0	41,737		194.02
194.03	07953	MANAGED CARE	0	93,142	0	93,142		194.03
194.04	07954	RENTAL AREA/PPOS	0	423,417	0	423,417		194.04
194.05	07955	SPECIALTY CLINICS	0	10,748	0	10,748		194.05
194.08	07958	ENT	0	25,192	0	25,192		194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	818,287	0	818,287		194.09
194.10	07960	PERU MALL	0	0	0	0		194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	47,253	0	47,253		194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	43,238	0	43,238		194.13
194.14	07964	HENRY	0	1,403	0	1,403		194.14
194.16	07966	SPRING VALLEY CLINIC	0	1,581	0	1,581		194.16
194.17	07967	OGLESBY MP OB	0	1,722	0	1,722		194.17
194.18	07968	FAMILY HEALTH CENTER	0	32,662	0	32,662		194.18

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	5,930	0	5,930		194.19
194.20	07970	PARATRANSIT	0	242,715	0	242,715		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	367,332	0	367,332		194.21
194.24	07974	SURGICAL ASSOCIATES	0	286	0	286		194.24
194.27	07977	MIDTOWN	0	46,544	0	46,544		194.27
194.28	07978	PAIN CLINIC	0	146,599	0	146,599		194.28
194.30	07980	WHC-PTON	0	0	0	0		194.30
194.31	07981	CFH	0	22,978	0	22,978		194.31
194.32	07982	PFS	0	740	0	740		194.32
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	67,586,539	0	67,586,539		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS OLD BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	CAPITAL RELATED COSTS OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,910	165	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,650	991,961	16,562	993,281	88	5.00
7.00	00700	OPERATION OF PLANT	912	268,840	4,489	35,192	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,115	119	0	0	8.00
9.00	00900	HOUSEKEEPING	430	28,396	474	11,316	0	9.00
10.00	01000	DIETARY	0	70,626	1,179	24,337	0	10.00
11.00	01100	CAFETERIA	0	24,283	405	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	24,372	407	3,566	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,589	628	28,434	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,953	209,029	3,490	153,683	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,456	45,653	762	16,667	0	31.00
43.00	04300	NURSERY	0	10,941	183	40,686	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	140,992	246,224	4,111	321,666	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,511	92	17,015	0	52.00
53.00	05300	ANESTHESIOLOGY	28,056	4,131	69	11,045	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,561	71,818	1,199	292,867	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	18,799	314	91,954	0	54.01
57.00	05700	CT SCAN	0	5,824	97	158,357	0	57.00
60.00	06000	LABORATORY	0	35,026	585	40,681	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,097	35	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	9,456	13,978	233	22,812	0	65.00
66.00	06600	PHYSICAL THERAPY	14,961	93,699	1,564	572	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	349	6	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,577	26	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,183	20	11,776	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,935	199	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,271	1,106	19,667	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	16,956	25,627	428	16,569	0	73.00
76.00	03020	SONOGRAPHY	0	4,794	80	42,874	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	13,360	223	6,644	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	151,969	2,537	276,104	0	90.00
91.00	09100	EMERGENCY	10,080	87,839	1,467	127,058	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	43,137	8,727	146	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	443,600	2,599,453	43,400	2,764,823	88	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,962	200	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	118,941	1,986	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	82,203	1,372	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	1,998	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	25,985	434	4,597	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	OLD BLDG & FIXT	NEW MVBLE EQUIP	OLD MVBLE EQUIP	
			0	1.00	1.01	2.00	2.01	
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	5,139	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	443,600	2,838,544	47,392	2,776,557	88	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	10,075	10,075				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,007,542	1,046	2,008,588			5.00
7.00	00700	OPERATION OF PLANT	309,433	171	85,183	394,787		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,234	15	7,612	1,791	16,652	8.00
9.00	00900	HOUSEKEEPING	40,616	177	30,761	7,150	0	9.00
10.00	01000	DIETARY	96,142	77	16,374	17,784	0	10.00
11.00	01100	CAFETERIA	24,688	210	28,984	6,115	0	11.00
13.00	01300	NURSING ADMINISTRATION	28,345	389	49,417	6,137	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,651	569	82,956	9,465	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	386,155	1,200	152,270	52,634	10,829	30.00
31.00	03100	INTENSIVE CARE UNIT	69,538	257	35,879	11,496	888	31.00
43.00	04300	NURSERY	51,810	20	5,063	2,755	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	712,993	739	235,063	62,000	1,765	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	22,618	144	19,792	1,388	0	52.00
53.00	05300	ANESTHESIOLOGY	43,301	0	9,247	1,040	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	512,445	304	93,109	18,084	1,111	54.00
54.01	05402	NUCLEAR MEDICINE	111,067	45	23,469	4,734	0	54.01
57.00	05700	CT SCAN	164,278	55	20,502	1,467	221	57.00
60.00	06000	LABORATORY	76,292	358	116,540	8,820	8	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,132	0	7,329	528	0	63.00
65.00	06500	RESPIRATORY THERAPY	46,479	148	24,355	3,520	32	65.00
66.00	06600	PHYSICAL THERAPY	110,796	457	61,692	23,594	888	66.00
67.00	06700	OCCUPATIONAL THERAPY	355	56	6,995	88	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,603	28	3,524	397	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,979	38	7,820	298	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,134	22	4,307	3,005	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,044	15	13,159	16,687	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	92,086	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	59,580	278	97,250	6,453	0	73.00
76.00	03020	SONOGRAPHY	47,748	65	21,007	1,207	0	76.00
76.01	03040	AUDIOLOGY	0	0	9,794	0	0	76.01
76.02	03160	CARDIAC REHAB	20,227	62	8,549	3,364	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	430,610	2,358	445,286	38,266	0	90.00
91.00	09100	EMERGENCY	226,444	319	66,379	22,118	888	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	28,521	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	52,010	184	41,342	2,198	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,851,364	9,806	1,951,616	334,583	16,630	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,162	0	434	3,012	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	120,927	12	5,880	29,950	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	17	2,669	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	83,575	0	2,984	20,699	0	194.04
194.05	07955	SPECIALTY CLINICS	1,998	0	157	0	22	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	31,016	85	22,661	6,543	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	45	7,213	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
194.21	07971	OCCUPATIONAL HEALTH	0	75	10,451	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	8	0	0	194.24
194.27	07977	MIDTOWN	5,139	0	183	0	0	194.27
194.28	07978	PAIN CLINIC	0	35	4,332	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	6,106,181	10,075	2,008,588	394,787	16,652	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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	78,704					9.00
10.00	01000	DIETARY	3,908	134,285				10.00
11.00	01100	CAFETERIA	3,117	0	63,114			11.00
13.00	01300	NURSING ADMINISTRATION	2,343	0	2,747	89,378		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,737	0	8,261	0	172,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,070	90,207	12,568	38,345	9,482	30.00
31.00	03100	INTENSIVE CARE UNIT	3,875	17,960	2,664	8,124	1,343	31.00
43.00	04300	NURSERY	356	0	431	1,315	550	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,264	6	8,927	27,233	26,474	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,572	0	1,294	3,950	914	52.00
53.00	05300	ANESTHESIOLOGY	65	0	0	0	4,819	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,328	0	3,801	0	11,405	54.00
54.01	05402	NUCLEAR MEDICINE	142	0	557	0	2,187	54.01
57.00	05700	CT SCAN	142	0	359	0	12,841	57.00
60.00	06000	LABORATORY	1,568	0	5,057	0	26,464	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	165	0	0	0	295	63.00
65.00	06500	RESPIRATORY THERAPY	379	0	1,553	0	2,707	65.00
66.00	06600	PHYSICAL THERAPY	781	0	0	0	6,645	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	785	67.00
68.00	06800	SPEECH PATHOLOGY	142	0	0	0	283	68.00
69.00	06900	ELECTROCARDIOLOGY	245	0	407	0	3,841	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	56	0	345	0	943	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	379	0	345	0	8,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,222	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,568	0	2,291	0	5,518	73.00
76.00	03020	SONOGRAPHY	142	0	580	0	5,262	76.00
76.01	03040	AUDIOLOGY	142	0	0	0	401	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	766	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	4,460	0	5,268	90.00
91.00	09100	EMERGENCY	1,568	0	3,413	10,411	7,576	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	577	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	0	2,036	0	2,396	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,054	108,173	62,096	89,378	151,135	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	142	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	5,474	194.00
194.01	07951	CONGREGATE LIVING	0	26,112	212	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	2,352	194.02
194.03	07953	MANAGED CARE	0	0	197	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	12,508	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	0	289	194.05
194.08	07958	ENT	0	0	0	0	1,420	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	0	466	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	2,663	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	2,436	194.13
194.14	07964	HENRY	0	0	0	0	79	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	89	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	97	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	1,840	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	334	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
194.21	07971	OCCUPATIONAL HEALTH	0	0	609	0	306	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	0	2,275	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	47	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	1,295	194.31
194.32	07982	PFS	0	0	0	0	42	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	78,704	134,285	63,114	89,378	172,639	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	783,760	0	783,760		30.00
31.00	03100	INTENSIVE CARE UNIT	0	152,024	0	152,024		31.00
43.00	04300	NURSERY	0	62,300	0	62,300		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,081,464	0	1,081,464		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	51,672	0	51,672		52.00
53.00	05300	ANESTHESIOLOGY	0	58,472	0	58,472		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	642,587	0	642,587		54.00
54.01	05402	NUCLEAR MEDICINE	0	142,201	0	142,201		54.01
57.00	05700	CT SCAN	0	199,865	0	199,865		57.00
60.00	06000	LABORATORY	0	235,107	0	235,107		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	10,449	0	10,449		63.00
65.00	06500	RESPIRATORY THERAPY	0	79,173	0	79,173		65.00
66.00	06600	PHYSICAL THERAPY	0	204,853	0	204,853		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,279	0	8,279		67.00
68.00	06800	SPEECH PATHOLOGY	0	5,977	0	5,977		68.00
69.00	06900	ELECTROCARDIOLOGY	0	25,628	0	25,628		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	20,812	0	20,812		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125,800	0	125,800		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	95,308	0	95,308		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	172,938	0	172,938		73.00
76.00	03020	SONOGRAPHY	0	76,011	0	76,011		76.00
76.01	03040	AUDIOLOGY	0	10,337	0	10,337		76.01
76.02	03160	CARDIAC REHAB	0	32,968	0	32,968		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	926,248	0	926,248		90.00
91.00	09100	EMERGENCY	0	339,116	0	339,116		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	29,098	0	29,098		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	100,166	0	100,166		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,672,613	0	5,672,613		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,750	0	15,750		190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	5,474	0	5,474		194.00
194.01	07951	CONGREGATE LIVING	0	183,093	0	183,093		194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	2,352	0	2,352		194.02
194.03	07953	MANAGED CARE	0	2,883	0	2,883		194.03
194.04	07954	RENTAL AREA/PPOS	0	119,766	0	119,766		194.04
194.05	07955	SPECIALTY CLINICS	0	2,466	0	2,466		194.05
194.08	07958	ENT	0	1,420	0	1,420		194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	60,771	0	60,771		194.09
194.10	07960	PERU MALL	0	0	0	0		194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	2,663	0	2,663		194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	2,436	0	2,436		194.13
194.14	07964	HENRY	0	79	0	79		194.14
194.16	07966	SPRING VALLEY CLINIC	0	89	0	89		194.16
194.17	07967	OGLESBY MP OB	0	97	0	97		194.17
194.18	07968	FAMILY HEALTH CENTER	0	1,840	0	1,840		194.18

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
194.19	07969	GRANVILLE CLINIC	0	334	0	334		194.19
194.20	07970	PARATRANSIT	0	7,258	0	7,258		194.20
194.21	07971	OCCUPATIONAL HEALTH	0	11,441	0	11,441		194.21
194.24	07974	SURGICAL ASSOCIATES	0	8	0	8		194.24
194.27	07977	MIDTOWN	0	7,597	0	7,597		194.27
194.28	07978	PAIN CLINIC	0	4,414	0	4,414		194.28
194.30	07980	WHC-PTON	0	0	0	0		194.30
194.31	07981	CFH	0	1,295	0	1,295		194.31
194.32	07982	PFS	0	42	0	42		194.32
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,106,181	0	6,106,181		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			1.00	1.01	2.00	2.01	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	316,786					1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT	0	316,786				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2,643,651			2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP			0	95		2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,106	1,106	0	0	27,895,998	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	110,704	110,704	945,736	95	2,896,998	5.00
7.00	00700	OPERATION OF PLANT	30,003	30,003	33,507	0	473,196	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	794	794	0	0	41,105	8.00
9.00	00900	HOUSEKEEPING	3,169	3,169	10,774	0	489,435	9.00
10.00	01000	DIETARY	7,882	7,882	23,172	0	212,305	10.00
11.00	01100	CAFETERIA	2,710	2,710	0	0	581,063	11.00
13.00	01300	NURSING ADMINISTRATION	2,720	2,720	3,395	0	1,078,101	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,195	4,195	27,073	0	1,575,326	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,328	23,328	146,327	0	3,325,401	30.00
31.00	03100	INTENSIVE CARE UNIT	5,095	5,095	15,869	0	713,271	31.00
43.00	04300	NURSERY	1,221	1,221	38,738	0	55,991	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27,479	27,479	306,269	0	2,046,857	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	615	615	16,201	0	399,831	52.00
53.00	05300	ANESTHESIOLOGY	461	461	10,516	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,015	8,015	278,848	0	841,368	54.00
54.01	05402	NUCLEAR MEDICINE	2,098	2,098	87,552	0	124,028	54.01
57.00	05700	CT SCAN	650	650	150,777	0	152,537	57.00
60.00	06000	LABORATORY	3,909	3,909	38,734	0	992,941	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	234	234	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,560	1,560	21,720	0	410,350	65.00
66.00	06600	PHYSICAL THERAPY	10,457	10,457	545	0	1,265,129	66.00
67.00	06700	OCCUPATIONAL THERAPY	39	39	0	0	156,176	67.00
68.00	06800	SPEECH PATHOLOGY	176	176	0	0	77,812	68.00
69.00	06900	ELECTROCARDIOLOGY	132	132	11,212	0	105,338	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,332	1,332	0	0	61,730	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,396	7,396	18,726	0	42,485	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,860	2,860	15,776	0	770,383	73.00
76.00	03020	SONOGRAPHY	535	535	40,822	0	181,173	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	1,491	1,491	6,326	0	172,004	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	16,960	16,960	262,888	0	6,512,834	90.00
91.00	09100	EMERGENCY	9,803	9,803	120,976	0	884,704	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	974	974	0	0	508,780	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	290,103	290,103	2,632,479	95	27,148,652	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,335	1,335	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	13,274	13,274	0	0	33,643	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	0	0	0	48,446	194.03
194.04	07954	RENTAL AREA/PPOS	9,174	9,174	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	1,902	0	92	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	2,900	2,900	4,377	0	234,201	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	OLD BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	OLD MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARY)	
			1.00	1.01	2.00	2.01	4.00	
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	125,946	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	0	0	0	206,726	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	4,893	0	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	0	98,292	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,838,544	47,392	2,776,557	88	5,429,547	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.960446	0.149603	1.050274	0.926316	0.194635	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					10,075	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.000361	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-11,322,146	56,264,393				5.00
7.00	00700	OPERATION OF PLANT	0	2,386,141	174,973			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	213,241	794	289,088		8.00
9.00	00900	HOUSEKEEPING	0	861,667	3,169	0	41,109	9.00
10.00	01000	DIETARY	0	458,674	7,882	0	2,041	10.00
11.00	01100	CAFETERIA	0	811,892	2,710	0	1,628	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,384,270	2,720	0	1,224	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,323,753	4,195	0	2,474	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,265,384	23,328	188,004	15,708	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,005,043	5,095	15,408	2,024	31.00
43.00	04300	NURSERY	0	141,835	1,221	0	186	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,584,582	27,479	30,643	3,272	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	554,414	615	0	821	52.00
53.00	05300	ANESTHESIOLOGY	0	259,027	461	0	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,608,159	8,015	19,282	1,216	54.00
54.01	05402	NUCLEAR MEDICINE	0	657,406	2,098	0	74	54.01
57.00	05700	CT SCAN	0	574,295	650	3,845	74	57.00
60.00	06000	LABORATORY	0	3,264,529	3,909	145	819	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	205,304	234	0	86	63.00
65.00	06500	RESPIRATORY THERAPY	0	682,241	1,560	564	198	65.00
66.00	06600	PHYSICAL THERAPY	0	1,728,107	10,457	15,408	408	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	195,931	39	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	98,707	176	0	74	68.00
69.00	06900	ELECTROCARDIOLOGY	0	219,041	132	0	128	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	120,642	1,332	0	29	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	368,608	7,396	0	198	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,579,503	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,724,156	2,860	0	819	73.00
76.00	03020	SONOGRAPHY	0	588,449	535	0	74	76.00
76.01	03040	AUDIOLOGY	0	274,350	0	0	74	76.01
76.02	03160	CARDIAC REHAB	0	239,473	1,491	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	12,473,234	16,960	0	0	90.00
91.00	09100	EMERGENCY	0	1,859,418	9,803	15,408	819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	798,943	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	1,158,062	974	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,322,146	54,668,481	148,290	288,707	34,502	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12,162	1,335	0	74	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	0	0	194.00
194.01	07951	CONGREGATE LIVING	0	164,706	13,274	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	0	0	194.02
194.03	07953	MANAGED CARE	0	74,772	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	83,575	9,174	0	6,533	194.04
194.05	07955	SPECIALTY CLINICS	0	4,389	0	381	0	194.05
194.08	07958	ENT	0	0	0	0	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	634,782	2,900	0	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	0	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	0	0	194.13
194.14	07964	HENRY	0	0	0	0	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	0	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	0	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	0	0	194.18
194.19	07969	GRANVILLE CLINIC	0	0	0	0	0	194.19

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A	5.00	7.00	8.00	9.00	
194.20	07970	PARATRANSIT	0	202,055	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	292,744	0	0	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	238	0	0	0	194.24
194.27	07977	MIDTOWN	0	5,139	0	0	0	194.27
194.28	07978	PAIN CLINIC	0	121,350	0	0	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	0	0	194.31
194.32	07982	PFS	0	0	0	0	0	194.32
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		11,322,146	2,866,307	269,159	1,086,974	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.201231	16.381425	0.931063	26.441266	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		2,008,588	394,787	16,652	78,704	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.035699	2.256274	0.057602	1.914520	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	OLD CAP REL COSTS-BLDG & FIXT						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	OLD CAP REL COSTS-MVBLE EQUIP						2.01
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	23,373					10.00
11.00	01100	CAFETERIA	0	26,535				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,155	256,229			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,473	0	236,555,177		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,701	5,285	109,929	12,989,434	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,126	1,120	23,290	1,839,498	0	31.00
43.00	04300	NURSERY	0	181	3,771	754,050	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1	3,753	78,071	36,265,337	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	544	11,323	1,251,456	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,601,627	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,598	0	15,622,696	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	234	0	2,996,371	0	54.01
57.00	05700	CT SCAN	0	151	0	17,589,939	0	57.00
60.00	06000	LABORATORY	0	2,126	0	36,318,854	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	404,395	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	653	0	3,708,465	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,102,709	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,074,678	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	387,486	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	171	0	5,261,198	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	145	0	1,292,101	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	145	0	11,192,501	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,414,022	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	963	0	7,558,452	0	73.00
76.00	03020	SONOGRAPHY	0	244	0	7,208,738	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	549,590	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,048,891	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	1,875	0	7,216,972	0	90.00
91.00	09100	EMERGENCY	0	1,435	29,845	10,377,735	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	789,860	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	856	0	3,282,864	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,828	26,107	256,229	207,099,919	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	ER PROFESSIONAL CHARGES	0	0	0	7,498,698	0	194.00
194.01	07951	CONGREGATE LIVING	4,545	89	0	0	0	194.01
194.02	07952	VALLEY ORTHOPEDIC AND SPORTS MEDICIN	0	0	0	3,221,681	0	194.02
194.03	07953	MANAGED CARE	0	83	0	0	0	194.03
194.04	07954	RENTAL AREA/PPOS	0	0	0	0	0	194.04
194.05	07955	SPECIALTY CLINICS	0	0	0	395,323	0	194.05
194.08	07958	ENT	0	0	0	1,944,604	0	194.08
194.09	07959	DURABLE MEDICAL EQUIPMENT	0	0	0	637,684	0	194.09
194.10	07960	PERU MALL	0	0	0	0	0	194.10
194.12	07962	FAMILY ORTHOPEDIC CENTER	0	0	0	3,647,503	0	194.12
194.13	07963	WOMEN'S HEALTH CENTER	0	0	0	3,337,589	0	194.13
194.14	07964	HENRY	0	0	0	108,317	0	194.14
194.16	07966	SPRING VALLEY CLINIC	0	0	0	122,000	0	194.16
194.17	07967	OGLESBY MP OB	0	0	0	132,956	0	194.17
194.18	07968	FAMILY HEALTH CENTER	0	0	0	2,521,169	0	194.18

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 7:38 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	MEDICAL RECORDS & LIBRARY (PATIENT CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
194.19	07969	GRANVILLE CLINIC	0	0	0	457,702	0	194.19
194.20	07970	PARATRANSIT	0	0	0	0	0	194.20
194.21	07971	OCCUPATIONAL HEALTH	0	256	0	418,864	0	194.21
194.24	07974	SURGICAL ASSOCIATES	0	0	0	0	0	194.24
194.27	07977	MIDTOWN	0	0	0	3,116,262	0	194.27
194.28	07978	PAIN CLINIC	0	0	0	64,094	0	194.28
194.30	07980	WHC-PTON	0	0	0	0	0	194.30
194.31	07981	CFH	0	0	0	1,773,657	0	194.31
194.32	07982	PFS	0	0	0	57,155	0	194.32
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)	734,058	1,062,710	1,786,006	3,064,591	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	31.406238	40.049369	6.970351	0.012955	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	134,285	63,114	89,378	172,639	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.745304	2.378519	0.348821	0.000730	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,735,533		7,735,533	66,979	7,802,512	30.00
31.00	03100	INTENSIVE CARE UNIT	1,687,816		1,687,816	0	1,687,816	31.00
43.00	04300	NURSERY	238,600		238,600	0	238,600	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,639,131		9,639,131	0	9,639,131	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	814,687		814,687	0	814,687	52.00
53.00	05300	ANESTHESIOLOGY	405,126		405,126	222,724	627,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,580,795		3,580,795	0	3,580,795	54.00
54.01	05402	NUCLEAR MEDICINE	874,211		874,211	0	874,211	54.01
57.00	05700	CT SCAN	939,971		939,971	0	939,971	57.00
60.00	06000	LABORATORY	4,562,952		4,562,952	0	4,562,952	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	257,964		257,964	0	257,964	63.00
65.00	06500	RESPIRATORY THERAPY	925,039	0	925,039	0	925,039	65.00
66.00	06600	PHYSICAL THERAPY	2,390,217	0	2,390,217	0	2,390,217	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,919	0	249,919	0	249,919	67.00
68.00	06800	SPEECH PATHOLOGY	128,430	0	128,430	0	128,430	68.00
69.00	06900	ELECTROCARDIOLOGY	343,672		343,672	0	343,672	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	190,052		190,052	0	190,052	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	719,981		719,981	0	719,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,155,763		3,155,763	0	3,155,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,477,335		3,477,335	0	3,477,335	73.00
76.00	03020	SONOGRAPHY	820,745		820,745	0	820,745	76.00
76.01	03040	AUDIOLOGY	338,635		338,635	0	338,635	76.01
76.02	03160	CARDIAC REHAB	325,675		325,675	0	325,675	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	15,429,661		15,429,661	0	15,429,661	90.00
91.00	09100	EMERGENCY	2,830,124		2,830,124	389,078	3,219,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,562,230		2,562,230		2,562,230	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	969,948		969,948	0	969,948	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,483,868		1,483,868		1,483,868	116.00
200.00		Subtotal (see instructions)	67,078,080	0	67,078,080	678,781	67,756,861	200.00
201.00		Less Observation Beds	2,562,230		2,562,230		2,562,230	201.00
202.00		Total (see instructions)	64,515,850	0	64,515,850	678,781	65,194,631	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,901,861		7,901,861			30.00
31.00	03100	INTENSIVE CARE UNIT	1,835,090		1,835,090			31.00
43.00	04300	NURSERY	748,307		748,307			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,165,839	28,867,630	36,033,469	0.267505	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,059,198	182,958	1,242,156	0.655865	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,970,686	4,583,519	6,554,205	0.061812	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,396,902	14,149,813	15,546,715	0.230325	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	146,932	2,835,865	2,982,797	0.293084	0.000000	54.01
57.00	05700	CT SCAN	1,858,045	15,654,809	17,512,854	0.053673	0.000000	57.00
60.00	06000	LABORATORY	6,507,844	29,662,528	36,170,372	0.126152	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	221,093	182,350	403,443	0.639406	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,649,593	1,050,839	3,700,432	0.249981	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	833,904	8,225,580	9,059,484	0.263836	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,334	926,032	1,069,366	0.233708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,761	352,737	386,498	0.332291	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,810,355	3,437,159	5,247,514	0.065492	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,514	1,282,778	1,284,292	0.147982	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,052,137	4,117,173	11,169,310	0.064461	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,060,506	353,516	4,414,022	0.714940	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,990,310	4,522,919	7,513,229	0.462828	0.000000	73.00
76.00	03020	SONOGRAPHY	918,038	6,258,471	7,176,509	0.114365	0.000000	76.00
76.01	03040	AUDIOLOGY	1,000	548,590	549,590	0.616159	0.000000	76.01
76.02	03160	CARDIAC REHAB	22,834	1,021,171	1,044,005	0.311948	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	65,000	7,106,772	7,171,772	2.151443	0.000000	90.00
91.00	09100	EMERGENCY	1,482,955	8,860,165	10,343,120	0.273624	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,421,758	3,630,635	5,052,393	0.507132	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	787,568	787,568	1.231574	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	3,281,811	3,281,811			116.00
200.00		Subtotal (see instructions)	54,298,796	151,883,388	206,182,184			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	54,298,796	151,883,388	206,182,184			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.267505		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.655865		52.00
53.00	05300	ANESTHESIOLOGY	0.095793		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230325		54.00
54.01	05402	NUCLEAR MEDICINE	0.293084		54.01
57.00	05700	CT SCAN	0.053673		57.00
60.00	06000	LABORATORY	0.126152		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.639406		63.00
65.00	06500	RESPIRATORY THERAPY	0.249981		65.00
66.00	06600	PHYSICAL THERAPY	0.263836		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233708		67.00
68.00	06800	SPEECH PATHOLOGY	0.332291		68.00
69.00	06900	ELECTROCARDIOLOGY	0.065492		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147982		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064461		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.714940		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462828		73.00
76.00	03020	SONOGRAPHY	0.114365		76.00
76.01	03040	AUDIOLOGY	0.616159		76.01
76.02	03160	CARDIAC REHAB	0.311948		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	2.151443		90.00
91.00	09100	EMERGENCY	0.311241		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.507132		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1.231574		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,735,533		7,735,533	66,979	7,802,512	30.00
31.00	03100	INTENSIVE CARE UNIT	1,687,816		1,687,816	0	1,687,816	31.00
43.00	04300	NURSERY	238,600		238,600	0	238,600	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,639,131		9,639,131	0	9,639,131	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	814,687		814,687	0	814,687	52.00
53.00	05300	ANESTHESIOLOGY	405,126		405,126	222,724	627,850	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,580,795		3,580,795	0	3,580,795	54.00
54.01	05402	NUCLEAR MEDICINE	874,211		874,211	0	874,211	54.01
57.00	05700	CT SCAN	939,971		939,971	0	939,971	57.00
60.00	06000	LABORATORY	4,562,952		4,562,952	0	4,562,952	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	257,964		257,964	0	257,964	63.00
65.00	06500	RESPIRATORY THERAPY	925,039	0	925,039	0	925,039	65.00
66.00	06600	PHYSICAL THERAPY	2,390,217	0	2,390,217	0	2,390,217	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,919	0	249,919	0	249,919	67.00
68.00	06800	SPEECH PATHOLOGY	128,430	0	128,430	0	128,430	68.00
69.00	06900	ELECTROCARDIOLOGY	343,672		343,672	0	343,672	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	190,052		190,052	0	190,052	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	719,981		719,981	0	719,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,155,763		3,155,763	0	3,155,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,477,335		3,477,335	0	3,477,335	73.00
76.00	03020	SONOGRAPHY	820,745		820,745	0	820,745	76.00
76.01	03040	AUDIOLOGY	338,635		338,635	0	338,635	76.01
76.02	03160	CARDIAC REHAB	325,675		325,675	0	325,675	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	15,429,661		15,429,661	0	15,429,661	90.00
91.00	09100	EMERGENCY	2,830,124		2,830,124	389,078	3,219,202	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,562,230		2,562,230		2,562,230	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	969,948		969,948	0	969,948	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,483,868		1,483,868		1,483,868	116.00
200.00		Subtotal (see instructions)	67,078,080	0	67,078,080	678,781	67,756,861	200.00
201.00		Less Observation Beds	2,562,230		2,562,230		2,562,230	201.00
202.00		Total (see instructions)	64,515,850	0	64,515,850	678,781	65,194,631	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,901,861		7,901,861			30.00
31.00	03100	INTENSIVE CARE UNIT	1,835,090		1,835,090			31.00
43.00	04300	NURSERY	748,307		748,307			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,165,839	28,867,630	36,033,469	0.267505	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,059,198	182,958	1,242,156	0.655865	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,970,686	4,583,519	6,554,205	0.061812	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,396,902	14,149,813	15,546,715	0.230325	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	146,932	2,835,865	2,982,797	0.293084	0.000000	54.01
57.00	05700	CT SCAN	1,858,045	15,654,809	17,512,854	0.053673	0.000000	57.00
60.00	06000	LABORATORY	6,507,844	29,662,528	36,170,372	0.126152	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	221,093	182,350	403,443	0.639406	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	2,649,593	1,050,839	3,700,432	0.249981	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	833,904	8,225,580	9,059,484	0.263836	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	143,334	926,032	1,069,366	0.233708	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	33,761	352,737	386,498	0.332291	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,810,355	3,437,159	5,247,514	0.065492	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,514	1,282,778	1,284,292	0.147982	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	7,052,137	4,117,173	11,169,310	0.064461	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,060,506	353,516	4,414,022	0.714940	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,990,310	4,522,919	7,513,229	0.462828	0.000000	73.00
76.00	03020	SONOGRAPHY	918,038	6,258,471	7,176,509	0.114365	0.000000	76.00
76.01	03040	AUDIOLOGY	1,000	548,590	549,590	0.616159	0.000000	76.01
76.02	03160	CARDIAC REHAB	22,834	1,021,171	1,044,005	0.311948	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	65,000	7,106,772	7,171,772	2.151443	0.000000	90.00
91.00	09100	EMERGENCY	1,482,955	8,860,165	10,343,120	0.273624	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,421,758	3,630,635	5,052,393	0.507132	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	787,568	787,568	1.231574	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	0	3,281,811	3,281,811			116.00
200.00		Subtotal (see instructions)	54,298,796	151,883,388	206,182,184			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	54,298,796	151,883,388	206,182,184			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.267505	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.655865	52.00
53.00	05300	ANESTHESIOLOGY	0.095793	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230325	54.00
54.01	05402	NUCLEAR MEDICINE	0.293084	54.01
57.00	05700	CT SCAN	0.053673	57.00
60.00	06000	LABORATORY	0.126152	60.00
60.01	06001	BLOOD LABORATORY	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.639406	63.00
65.00	06500	RESPIRATORY THERAPY	0.249981	65.00
66.00	06600	PHYSICAL THERAPY	0.263836	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233708	67.00
68.00	06800	SPEECH PATHOLOGY	0.332291	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065492	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147982	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064461	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.714940	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462828	73.00
76.00	03020	SONOGRAPHY	0.114365	76.00
76.01	03040	AUDIOLOGY	0.616159	76.01
76.02	03160	CARDIAC REHAB	0.311948	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
90.00	09000	CLINIC	2.151443	90.00
91.00	09100	EMERGENCY	0.311241	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.507132	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	1.231574	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
114.00	11400	UTILIZATION REVIEW-SNF		114.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II Date/Time Prepared: 2/23/2018 7:38 am

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		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,639,131	1,081,464	8,557,667	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	814,687	51,672	763,015	0	0	52.00
53.00	05300	ANESTHESIOLOGY	405,126	58,472	346,654	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,580,795	642,587	2,938,208	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	874,211	142,201	732,010	0	0	54.01
57.00	05700	CT SCAN	939,971	199,865	740,106	0	0	57.00
60.00	06000	LABORATORY	4,562,952	235,107	4,327,845	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	257,964	10,449	247,515	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	925,039	79,173	845,866	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,390,217	204,853	2,185,364	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	249,919	8,279	241,640	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	128,430	5,977	122,453	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	343,672	25,628	318,044	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	190,052	20,812	169,240	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	719,981	125,800	594,181	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,155,763	95,308	3,060,455	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,477,335	172,938	3,304,397	0	0	73.00
76.00	03020	SONOGRAPHY	820,745	76,011	744,734	0	0	76.00
76.01	03040	AUDIOLOGY	338,635	10,337	328,298	0	0	76.01
76.02	03160	CARDIAC REHAB	325,675	32,968	292,707	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	15,429,661	926,248	14,503,413	0	0	90.00
91.00	09100	EMERGENCY	2,830,124	339,116	2,491,008	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,562,230	257,376	2,304,854	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	969,948	29,098	940,850	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
116.00	11600	HOSPICE	1,483,868	100,166	1,383,702	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	57,416,131	4,931,905	52,484,226	0	0	200.00
201.00		Less Observation Beds	2,562,230	257,376	2,304,854	0	0	201.00
202.00		Total (line 200 minus line 201)	54,853,901	4,674,529	50,179,372	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	9,639,131	36,033,469	0.267505		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	814,687	1,242,156	0.655865		52.00
53.00	05300	ANESTHESIOLOGY	405,126	6,554,205	0.061812		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,580,795	15,546,715	0.230325		54.00
54.01	05402	NUCLEAR MEDICINE	874,211	2,982,797	0.293084		54.01
57.00	05700	CT SCAN	939,971	17,512,854	0.053673		57.00
60.00	06000	LABORATORY	4,562,952	36,170,372	0.126152		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	257,964	403,443	0.639406		63.00
65.00	06500	RESPIRATORY THERAPY	925,039	3,700,432	0.249981		65.00
66.00	06600	PHYSICAL THERAPY	2,390,217	9,059,484	0.263836		66.00
67.00	06700	OCCUPATIONAL THERAPY	249,919	1,069,366	0.233708		67.00
68.00	06800	SPEECH PATHOLOGY	128,430	386,498	0.332291		68.00
69.00	06900	ELECTROCARDIOLOGY	343,672	5,247,514	0.065492		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	190,052	1,284,292	0.147982		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	719,981	11,169,310	0.064461		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,155,763	4,414,022	0.714940		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,477,335	7,513,229	0.462828		73.00
76.00	03020	SONOGRAPHY	820,745	7,176,509	0.114365		76.00
76.01	03040	AUDIOLOGY	338,635	549,590	0.616159		76.01
76.02	03160	CARDIAC REHAB	325,675	1,044,005	0.311948		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
90.00	09000	CLINIC	15,429,661	7,171,772	2.151443		90.00
91.00	09100	EMERGENCY	2,830,124	10,343,120	0.273624		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,562,230	5,052,393	0.507132		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	969,948	787,568	1.231574		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
116.00	11600	HOSPICE	1,483,868	3,281,811	0.452149		116.00
200.00		Subtotal (sum of lines 50 thru 199)	57,416,131	195,696,926			200.00
201.00		Less Observation Beds	2,562,230	0			201.00
202.00		Total (line 200 minus line 201)	54,853,901	195,696,926			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/23/2018 7:38 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	783,760	676	783,084	8,148	96.11	30.00
31.00	INTENSIVE CARE UNIT	152,024		152,024	836	181.85	31.00
43.00	NURSERY	62,300		62,300	678	91.89	43.00
200.00	Total (lines 30 through 199)	998,084		997,408	9,662		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	3,218	309,282	30.00
31.00	INTENSIVE CARE UNIT	532	96,744	31.00
43.00	NURSERY	0	0	43.00
200.00	Total (lines 30 through 199)	3,750	406,026	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/23/2018 7:38 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	1,081,464	36,033,469	0.030013	3,545,170	106,401	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,672	1,242,156	0.041599	343	14	52.00
53.00	05300	ANESTHESIOLOGY	58,472	6,554,205	0.008921	1,001,448	8,934	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	642,587	15,546,715	0.041333	1,211,629	50,080	54.00
54.01	05402	NUCLEAR MEDICINE	142,201	2,982,797	0.047674	98,526	4,697	54.01
57.00	05700	CT SCAN	199,865	17,512,854	0.011412	1,377,944	15,725	57.00
60.00	06000	LABORATORY	235,107	36,170,372	0.006500	4,497,805	29,236	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,449	403,443	0.025900	145,489	3,768	63.00
65.00	06500	RESPIRATORY THERAPY	79,173	3,700,432	0.021396	791,180	16,928	65.00
66.00	06600	PHYSICAL THERAPY	204,853	9,059,484	0.022612	495,378	11,201	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,279	1,069,366	0.007742	83,979	650	67.00
68.00	06800	SPEECH PATHOLOGY	5,977	386,498	0.015465	30,323	469	68.00
69.00	06900	ELECTROCARDIOLOGY	25,628	5,247,514	0.004884	1,514,936	7,399	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,812	1,284,292	0.016205	1,380	22	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,800	11,169,310	0.011263	6,402,203	72,108	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,308	4,414,022	0.021592	1,928,098	41,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,938	7,513,229	0.023018	1,794,067	41,296	73.00
76.00	03020	SONOGRAPHY	76,011	7,176,509	0.010592	597,997	6,334	76.00
76.01	03040	AUDIOLOGY	10,337	549,590	0.018809	102	2	76.01
76.02	03160	CARDIAC REHAB	32,968	1,044,005	0.031578	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	926,248	7,171,772	0.129152	64,171	8,288	90.00
91.00	09100	EMERGENCY	339,116	10,343,120	0.032787	1,280,743	41,992	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	257,376	5,052,393	0.050941	247,934	12,630	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,802,641	191,627,547		27,110,845	479,805	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	8,148	0.00	3,218	30.00
31.00	03100	INTENSIVE CARE UNIT		0	836	0.00	532	31.00
43.00	04300	NURSERY		0	678	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	9,662		3,750	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	36,033,469	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,242,156	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,554,205	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,546,715	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	2,982,797	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	17,512,854	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	36,170,372	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	403,443	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,700,432	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,059,484	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,069,366	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	386,498	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,247,514	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,284,292	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,169,310	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,414,022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,513,229	0.000000	73.00
76.00	03020	SONOGRAPHY	0	0	0	7,176,509	0.000000	76.00
76.01	03040	AUDIOLOGY	0	0	0	549,590	0.000000	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,044,005	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	7,171,772	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,343,120	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,052,393	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	191,627,547		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,545,170	0	7,941,224	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	343	0	101	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,001,448	0	1,403,031	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,211,629	0	5,427,283	0	54.00
54.01	05402	NUCLEAR MEDICINE	0.000000	98,526	0	1,311,328	0	54.01
57.00	05700	CT SCAN	0.000000	1,377,944	0	5,665,808	0	57.00
60.00	06000	LABORATORY	0.000000	4,497,805	0	4,220,892	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	145,489	0	61,042	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	791,180	0	492,040	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	495,378	0	35,767	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	83,979	0	2,167	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	30,323	0	1,666	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	1,514,936	0	1,369,326	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,380	0	100,422	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,402,203	0	1,849,701	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,928,098	0	167,864	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,794,067	0	2,271,703	0	73.00
76.00	03020	SONOGRAPHY	0.000000	597,997	0	1,465,096	0	76.00
76.01	03040	AUDIOLOGY	0.000000	102	0	78,305	0	76.01
76.02	03160	CARDIAC REHAB	0.000000	0	0	95,410	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	64,171	0	1,466,744	0	90.00
91.00	09100	EMERGENCY	0.000000	1,280,743	0	2,505,263	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	247,934	0	805,477	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		27,110,845	0	38,737,660	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/23/2018 7:38 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	0.267505	7,941,224	0	0	2,124,317	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.655865	101	0	0	66	52.00
53.00	05300	ANESTHESIOLOGY	0.061812	1,403,031	0	0	86,724	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230325	5,427,283	0	0	1,250,039	54.00
54.01	05402	NUCLEAR MEDICINE	0.293084	1,311,328	0	0	384,329	54.01
57.00	05700	CT SCAN	0.053673	5,665,808	0	0	304,101	57.00
60.00	06000	LABORATORY	0.126152	4,220,892	1,238	0	532,474	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.639406	61,042	0	0	39,031	63.00
65.00	06500	RESPIRATORY THERAPY	0.249981	492,040	0	0	123,001	65.00
66.00	06600	PHYSICAL THERAPY	0.263836	35,767	0	0	9,437	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233708	2,167	0	0	506	67.00
68.00	06800	SPEECH PATHOLOGY	0.332291	1,666	0	0	554	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065492	1,369,326	0	0	89,680	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147982	100,422	0	0	14,861	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064461	1,849,701	0	0	119,234	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.714940	167,864	0	0	120,013	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462828	2,271,703	705	107,198	1,051,408	73.00
76.00	03020	SONOGRAPHY	0.114365	1,465,096	0	0	167,556	76.00
76.01	03040	AUDIOLOGY	0.616159	78,305	0	0	48,248	76.01
76.02	03160	CARDIAC REHAB	0.311948	95,410	0	0	29,763	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.151443	1,466,744	16	0	3,155,616	90.00
91.00	09100	EMERGENCY	0.273624	2,505,263	0	0	685,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.507132	805,477	0	0	408,483	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1.231574		0			95.00
200.00		Subtotal (see instructions)		38,737,660	1,959	107,198	10,744,941	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		38,737,660	1,959	107,198	10,744,941	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/23/2018 7:38 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05402	NUCLEAR MEDICINE	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	156	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326	49,614		73.00
76.00	03020	SONOGRAPHY	0	0		76.00
76.01	03040	AUDIOLOGY	0	0		76.01
76.02	03160	CARDIAC REHAB	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	34	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	516	49,614		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	516	49,614		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I | Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | 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	783,760	676	783,084	8,148	96.11	30.00
31.00	INTENSIVE CARE UNIT	152,024		152,024	836	181.85	31.00
43.00	NURSERY	62,300		62,300	678	91.89	43.00
200.00	Total (lines 30 through 199)	998,084		997,408	9,662		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	911	87,556	30.00
31.00	INTENSIVE CARE UNIT	57	10,365	31.00
43.00	NURSERY	462	42,453	43.00
200.00	Total (lines 30 through 199)	1,430	140,374	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,081,464	36,033,469	0.030013	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,672	1,242,156	0.041599	0	0	52.00
53.00	05300	ANESTHESIOLOGY	58,472	6,554,205	0.008921	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	642,587	15,546,715	0.041333	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	142,201	2,982,797	0.047674	0	0	54.01
57.00	05700	CT SCAN	199,865	17,512,854	0.011412	0	0	57.00
60.00	06000	LABORATORY	235,107	36,170,372	0.006500	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	10,449	403,443	0.025900	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	79,173	3,700,432	0.021396	0	0	65.00
66.00	06600	PHYSICAL THERAPY	204,853	9,059,484	0.022612	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,279	1,069,366	0.007742	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,977	386,498	0.015465	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,628	5,247,514	0.004884	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,812	1,284,292	0.016205	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,800	11,169,310	0.011263	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,308	4,414,022	0.021592	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	172,938	7,513,229	0.023018	0	0	73.00
76.00	03020	SONOGRAPHY	76,011	7,176,509	0.010592	0	0	76.00
76.01	03040	AUDIOLOGY	10,337	549,590	0.018809	0	0	76.01
76.02	03160	CARDIAC REHAB	32,968	1,044,005	0.031578	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	926,248	7,171,772	0.129152	0	0	90.00
91.00	09100	EMERGENCY	339,116	10,343,120	0.032787	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	257,376	5,052,393	0.050941	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	4,802,641	191,627,547		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	0	8,148	0.00	911	30.00
31.00	03100	INTENSIVE CARE UNIT		0	836	0.00	57	31.00
43.00	04300	NURSERY		0	678	0.00	462	43.00
200.00		Total (lines 30 through 199)		0	9,662		1,430	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	36,033,469	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,242,156	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,554,205	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,546,715	0.000000	54.00
54.01	05402	NUCLEAR MEDICINE	0	0	0	2,982,797	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	17,512,854	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	36,170,372	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	403,443	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,700,432	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,059,484	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,069,366	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	386,498	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,247,514	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,284,292	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,169,310	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,414,022	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,513,229	0.000000	73.00
76.00	03020	SONOGRAPHY	0	0	0	7,176,509	0.000000	76.00
76.01	03040	AUDIOLOGY	0	0	0	549,590	0.000000	76.01
76.02	03160	CARDIAC REHAB	0	0	0	1,044,005	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
90.00	09000	CLINIC	0	0	0	7,171,772	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,343,120	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	5,052,393	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	191,627,547		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05402	NUCLEAR MEDICINE	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03020	SONOGRAPHY	0.000000	0	0	0	0	76.00
76.01	03040	AUDIOLOGY	0.000000	0	0	0	0	76.01
76.02	03160	CARDIAC REHAB	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 7:38 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)	8,179	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,148	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,470	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	23	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)	3,218	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)	8	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)	23	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	212.56	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	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)	7,802,512	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)	1,700	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)	5,034	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)	6,734	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,795,778	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)	7,795,778	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)	956.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,078,886	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,078,886	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 7:38 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,687,816	836	2,018.92	532	1,074,065	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)	5,896,824	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	10,049,775	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)	406,026	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	479,805	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	885,831	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	9,163,944	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)	1,700	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	5,034	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	6,734	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)	2,678	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	956.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,562,230	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 7:38 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	783,760	7,802,512	0.100450	2,562,230	257,376	90.00
91.00	Nursing School cost	0	7,802,512	0.000000	2,562,230	0	91.00
92.00	Allied health cost	0	7,802,512	0.000000	2,562,230	0	92.00
93.00	All other Medical Education	0	7,802,512	0.000000	2,562,230	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 7:38 am

Title XIX | 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)	8,179	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,148	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,470	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	23	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)	911	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)	678	15.00
16.00	Nursery days (title V or XIX only)	462	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	212.56	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	218.85	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)	7,802,512	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)	1,700	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)	5,034	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)	6,734	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,795,778	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)	7,795,778	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)	956.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	871,617	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)	871,617	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 7:38 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	238,600	678	351.92	462	162,587	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,687,816	836	2,018.92	57	115,078	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)	1,149,282	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)	140,374	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)	140,374	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,008,908	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)	2,678	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	956.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,562,230	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 7:38 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	783,760	7,802,512	0.100450	2,562,230	257,376	90.00
91.00	Nursing School cost	0	7,802,512	0.000000	2,562,230	0	91.00
92.00	Allied health cost	0	7,802,512	0.000000	2,562,230	0	92.00
93.00	All other Medical Education	0	7,802,512	0.000000	2,562,230	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/23/2018 7:38 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,355,555		30.00
31.00	03100	INTENSIVE CARE UNIT		1,250,645		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.267505	3,545,170	948,351	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.655865	343	225	52.00
53.00	05300	ANESTHESIOLOGY	0.095793	1,001,448	95,932	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230325	1,211,629	279,068	54.00
54.01	05402	NUCLEAR MEDICINE	0.293084	98,526	28,876	54.01
57.00	05700	CT SCAN	0.053673	1,377,944	73,958	57.00
60.00	06000	LABORATORY	0.126152	4,497,805	567,407	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.639406	145,489	93,027	63.00
65.00	06500	RESPIRATORY THERAPY	0.249981	791,180	197,780	65.00
66.00	06600	PHYSICAL THERAPY	0.263836	495,378	130,699	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233708	83,979	19,627	67.00
68.00	06800	SPEECH PATHOLOGY	0.332291	30,323	10,076	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065492	1,514,936	99,216	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147982	1,380	204	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064461	6,402,203	412,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.714940	1,928,098	1,378,474	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462828	1,794,067	830,344	73.00
76.00	03020	SONOGRAPHY	0.114365	597,997	68,390	76.00
76.01	03040	AUDIOLOGY	0.616159	102	63	76.01
76.02	03160	CARDIAC REHAB	0.311948	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.151443	64,171	138,060	90.00
91.00	09100	EMERGENCY	0.311241	1,280,743	398,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.507132	247,934	125,735	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		27,110,845	5,896,824	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)		27,110,845		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0143 | Component CCN: 14-U143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Swing Beds - SNF | 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	0.267505	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.655865	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.061812	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230325	1,508	347	54.00
54.01	05402	NUCLEAR MEDICINE	0.293084	0	0	54.01
57.00	05700	CT SCAN	0.053673	0	0	57.00
60.00	06000	LABORATORY	0.126152	12,157	1,534	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.639406	1,236	790	63.00
65.00	06500	RESPIRATORY THERAPY	0.249981	5,586	1,396	65.00
66.00	06600	PHYSICAL THERAPY	0.263836	4,372	1,153	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233708	891	208	67.00
68.00	06800	SPEECH PATHOLOGY	0.332291	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.065492	303	20	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147982	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.064461	43,973	2,835	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.714940	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.462828	10,321	4,777	73.00
76.00	03020	SONOGRAPHY	0.114365	0	0	76.00
76.01	03040	AUDIOLOGY	0.616159	0	0	76.01
76.02	03160	CARDIAC REHAB	0.311948	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.151443	0	0	90.00
91.00	09100	EMERGENCY	0.273624	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.507132	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		80,347	13,060	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)		80,347		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/23/2018 7:38 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	7,373,886	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)	12,239	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	48.58	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.71	30.00
31.00	Percentage of Medicaid patient days (see instructions)	20.95	31.00
32.00	Sum of lines 30 and 31	21.66	32.00
33.00	Allowable disproportionate share percentage (see instructions)	7.08	33.00
34.00	Disproportionate share adjustment (see instructions)	130,518	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/23/2018 7:38 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000024597	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	147,028	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	147,028	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	147,028		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)	7,663,671		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	9,053,719		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		8,706,207	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		591,248	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		9,297,455	59.00
60.00	Primary payer payments		212	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,297,243	61.00
62.00	Deductibles billed to program beneficiaries		917,523	62.00
63.00	Coinsurance billed to program beneficiaries		8,973	63.00
64.00	Allowable bad debts (see instructions)		129,252	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		84,014	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		95,690	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,454,761	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		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		-1,037	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-3,232	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-7,265	70.93
70.94	HRR adjustment amount (see instructions)		-22,629	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/23/2018 7:38 am
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		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		8,420,598	71.00
71.01	Sequestration adjustment (see instructions)		168,412	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		8,146,078	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		106,108	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		17,010	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)		1,042,536	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.9990048580	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		-1,037	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.9969	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		-3,232	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/23/2018 7:38 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	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,373,886	0		7,299,925	7,299,925	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	12,239	0	0	12,239	12,239	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	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	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	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0708	0.0708	0.0708	0.0708		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	130,518	0	0	130,518	130,518	11.00
11.01	Uncompensated care payments	36.00	147,028	0	0	187,700	187,700	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	7,663,671	0	0	7,663,671	7,663,671	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,053,719	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,706,207	0	0	8,706,207	8,706,207	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	591,248	0	0	591,248	591,248	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/23/2018 7:38 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	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	9,297,455	9,297,455	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	588,760	0	0	588,760	588,760	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	2,488	0	0	2,488	2,488	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	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	591,248	0	0	591,248	591,248	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	0.076964		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				715,569	715,569	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: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/23/2018 7:38 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	7,373,886		7,299,925	7,299,925	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	12,239	0	12,239	12,239	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0708	0.0708	0.0708		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	130,518	0	130,518	130,518	11.00
11.01	Uncompensated care payments	36.00	147,028	0	147,028	147,028	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	7,663,671	0	7,663,671	7,663,671	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	9,053,719	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	8,706,207	0	8,706,207	8,706,207	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	591,248	0	591,248	591,248	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	9,297,455	9,297,455	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/23/2018 7:38 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	588,760	0	588,760	588,760	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	2,488	0	2,488	2,488	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	591,248	0	591,248	591,248	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	-7,265	0	-7,265	-7,265	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	-1,037	0	-1,037	-1,037	30.01
31.00	HRR adjustment (see instructions)	70.94	-22,629	0	-22,629	-22,629	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-3,232	0	-3,232	-3,232	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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/23/2018 7:38 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	50,130	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	10,744,941	2.00
3.00	OPPS payments	7,966,929	3.00
4.00	Outlier payment (see instructions)	121,484	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.799	5.00
6.00	Line 2 times line 5	8,585,208	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	94.21	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)	50,130	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	109,157	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)	109,157	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)	109,157	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	59,027	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (see instructions)	50,130	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	8,088,413	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)	1,734,054	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	6,404,489	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	6,404,489	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	6,404,489	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)	250,174	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	162,613	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	174,461	36.00
37.00	Subtotal (see instructions)	6,567,102	37.00
38.00	MSP-LCC reconciliation amount from PS&R	2,076	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	6,565,026	40.00
40.01	Sequestration adjustment (see instructions)	131,301	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	6,556,855	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-123,130	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2018 7:38 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		7,250,893		6,434,828	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	07/13/2017	895,185	07/13/2017	122,027	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)		895,185		122,027	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)		8,146,078		6,556,855	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		106,108		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		123,130	6.02
7.00	Total Medicare program liability (see instructions)		8,252,186		6,433,725	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: 14-0143 | Component CCN: 14-U143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2018 7:38 am

Title XVIII | Swing Beds - SNF | 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		9,273		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)		9,273		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)		9,273		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: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/23/2018 7:38 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 14-0143 Component CCN: 14-U143	Period: From 10/01/2016 To 09/30/2017	Worksheet E-2 Date/Time Prepared: 2/23/2018 7:38 am
	Title XVIII	Swing Beds - SNF	PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	11,555	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	31	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	11,555	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	11,555	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	11,555	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,093	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	9,462	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	9,462	0	19.00
19.01	Sequestration adjustment (see instructions)	189	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	9,273	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/23/2018 7:38 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	2,021,019	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	19,608,356	0	0	0	4.00
5.00	Other receivable	418,399	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,669,000	0	0	0	6.00
7.00	Inventory	2,214,033	0	0	0	7.00
8.00	Prepaid expenses	512,383	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	21,105,190	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	2,691,261	0	0	0	12.00
13.00	Land improvements	2,938,993	0	0	0	13.00
14.00	Accumulated depreciation	-2,220,369	0	0	0	14.00
15.00	Buildings	68,542,298	0	0	0	15.00
16.00	Accumulated depreciation	-35,767,775	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	29,679,755	0	0	0	23.00
24.00	Accumulated depreciation	-22,425,207	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	454,419	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	43,893,375	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	30,283,125	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,726,037	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	32,009,162	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	97,007,727	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	6,805,303	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,128,937	0	0	0	38.00
39.00	Payroll taxes payable	267,615	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,851,636	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	187,469	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	13,240,960	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	21,256,452	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	1,799,984	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,056,436	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	36,297,396	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	60,710,331				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	60,710,331	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	97,007,727	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/23/2018 7:38 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		55,166,732		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,537,151				2.00
3.00	Total (sum of line 1 and line 2)		60,703,883		0		3.00
4.00	CONTRIBUTIONS	372,888		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	1,435		0		0	5.00
6.00	DISTRIBUTIONS	341,610		0		0	6.00
7.00	UNRESTRICTED CONTRIBUTIONS	20		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		715,953		0		10.00
11.00	Subtotal (line 3 plus line 10)		61,419,836		0		11.00
12.00	EQUITY TRANSFER	330,566		0		0	12.00
13.00	CHANGE IN FOUNDATION INTEREST	378,939		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		709,505		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		60,710,331		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2018 7:38 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,032,473		10,032,473	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	10,032,473		10,032,473	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,572,400		3,572,400	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)	3,572,400		3,572,400	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,604,873		13,604,873	17.00
18.00	Ancillary services	43,435,895	148,170,406	191,606,301	18.00
19.00	Outpatient services	0	28,666,574	28,666,574	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	789,860	789,860	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	3,282,864	3,282,864	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)	57,040,768	180,909,704	237,950,472	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		81,855,945		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		81,855,945		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0143 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-3 | Date/Time Prepared: 2/23/2018 7:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	237,950,472	1.00
2.00	Less contractual allowances and discounts on patients' accounts	155,086,058	2.00
3.00	Net patient revenues (line 1 minus line 2)	82,864,414	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	81,855,945	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,008,469	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	205,077	14.00
15.00	Revenue from rental of living quarters	64,321	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	265,118	17.00
18.00	Revenue from sale of medical records and abstracts	2,468	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	136,238	22.00
23.00	Governmental appropriations	0	23.00
24.00	LOSS ON DISPOSAL OF EQUIPMENT	126,647	24.00
24.01	EMR REVENUE	566,938	24.01
24.02	NET RENTAL INCOME	6,004	24.02
24.03	OTHER REVENUE	24,030	24.03
24.04	PARATRANSIT	241,532	24.04
24.05	OUTSIDE REHABILITATION SERVICES	2,970	24.05
24.06	CONTRIBUTIONS SPENT FOR OPERATIONS	29,301	24.06
24.07	INVESTMENT INCOME	2,853,323	24.07
25.00	Total other income (sum of lines 6-24)	4,523,967	25.00
26.00	Total (line 5 plus line 25)	5,532,436	26.00
27.00	NET RENTAL LOSS	0	27.00
27.01	OTHER	0	27.01
27.02	CHANGE IN EQUITY GAINS AND LOSSES	-4,715	27.02
27.03	MISCELLANEOUS	0	27.03
27.04	OTHER EXPENSES (SPECIFY)	0	27.04
27.05	OTHER EXPENSES (SPECIFY)	0	27.05
28.00	Total other expenses (sum of line 27 and subscripts)	-4,715	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,537,151	29.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143 | Hospice CCN: 14-1595 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O | Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	50,385	50,385	0	50,385	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	11,647	11,647	0	11,647	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	32,410	32,410	0	32,410	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0	0	0	0	13.00
14.00	PHARMACY*	0	2,091	2,091	0	2,091	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES**	0	41,301	41,301	0	41,301	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	447,246	0	447,246	0	447,246	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	37,461	0	37,461	0	37,461	33.00
34.00	SPIRITUAL COUNSELING**	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	24,073	0	24,073	0	24,073	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	403,549	403,549	0	403,549	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	508,780	541,383	1,050,163	0	1,050,163	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0143 | Hospice CCN: 14-1595 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O | Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	50,385		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	11,647		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	32,410		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14.00	PHARMACY*	0	2,091		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	0		25.00
26.00	PHYSICIAN SERVICES**	0	41,301		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	447,246		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	37,461		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	24,073		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	403,549		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	0		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	0	1,050,163		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 14-0143 | Hospice CCN: 14-1595 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-1 | Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	0	0	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	0		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	0		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 14-0143 | Hospice CCN: 14-1595 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-2 | Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	40,306	40,306	0	40,306	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	439,672	0	439,672	0	439,672	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	36,827	0	36,827	0	36,827	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	23,665	0	23,665	0	23,665	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	397,011	397,011	0	397,011	46.00
100.00	TOTAL *	500,164	437,317	937,481	0	937,481	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	40,306		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	439,672		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	36,827		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	23,665		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	397,011		46.00
100.00	TOTAL *	0	937,481		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 14-0143 | Hospice CCN: 14-1595 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-3 | Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	335	335	0	335	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	371	0	371	0	371	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	31	0	31	0	31	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	20	0	20	0	20	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	34	34	0	34	46.00
100.00	TOTAL *	422	369	791	0	791	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	335		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	371		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	31		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	20		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	34		46.00
100.00	TOTAL *	0	791		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE

Provider CCN: 14-0143 | Hospice CCN: 14-1595 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-4 | Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED	0	0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	660	660	0	660	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	7,203	0	7,203	0	7,203	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	603	0	603	0	603	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	388	0	388	0	388	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	6,504	6,504	0	6,504	46.00
100.00	TOTAL *	8,194	7,164	15,358	0	15,358	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSICIAN SERVICES	0	660		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	7,203		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	603		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	388		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	6,504		46.00
100.00	TOTAL *	0	15,358		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 14-0143 Hospice CCN: 14-1595

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

Worksheet O-5

Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	8,873	8,873	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	99,026	99,026	3.00
4.00	ADMINISTRATIVE & GENERAL	50,385	267,320	317,705	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	15,956	15,956	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	11,647	0	11,647	10.00
11.00	MEDICAL RECORDS	0	42,530	42,530	11.00
12.00	STAFF TRANSPORTATION	32,410		32,410	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	2,091	0	2,091	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	937,481		937,481	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	791		791	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	15,358		15,358	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0		0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,050,163	433,705	1,483,868	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

Worksheet O-6 Part I
Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,873	8,873				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	99,026	0	0	99,026		3.00
4.00	ADMINISTRATIVE & GENERAL	317,705	8,873	0	0	326,578	4.00
5.00	PLANT OPERATION & MAINTENANCE	15,956	0	0	0	15,956	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	11,647	0	0	0	11,647	10.00
11.00	MEDICAL RECORDS	42,530	0	0	0	42,530	11.00
12.00	STAFF TRANSPORTATION	32,410	0	0	0	32,410	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	2,091	0	0	0	2,091	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	937,481			97,349	1,034,830	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	791	0	0	82	873	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	15,358	0	0	1,595	16,953	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0				0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	1,483,868	8,873	0	99,026	1,483,868	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

Worksheet O-6 Part I
Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	326,578					4.00
5.00	PLANT OPERATION & MAINTENANCE	4,503	20,459				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0			6.00
7.00	HOUSEKEEPING	0	0		0		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3,287	0		0		10.00
11.00	MEDICAL RECORDS	12,002	0		0		11.00
12.00	STAFF TRANSPORTATION	9,146	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0		13.00
14.00	PHARMACY	590	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	292,020					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	246	3,613	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	4,784	16,846	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	326,578	20,459	0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143 Hospice CCN: 14-1595

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

Worksheet O-6 Part I Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	14,934				10.00
11.00	MEDICAL RECORDS	0		54,532			11.00
12.00	STAFF TRANSPORTATION	0			41,556		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	14,681	53,609	41,556	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	12	45	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	241	878	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	0	14,934	54,532	41,556	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

Worksheet O-6 Part I
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Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE (DELETED)	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	2,681					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	2,636	0	0		1,439,332	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	2	0	0	0	4,791	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	43	0	0	0	39,745	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	2,681	0	0	0	1,483,868	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	974					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	508,780			3.00
4.00	ADMINISTRATIVE & GENERAL	974	0	0	-326,578	1,157,290	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	15,956	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	11,647	10.00
11.00	MEDICAL RECORDS	0	0	0	0	42,530	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	32,410	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	0	13.00
14.00	PHARMACY	0	0	0	0	2,091	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			500,164	0	1,034,830	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	422	0	873	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	8,194	0	16,953	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	8,873	0	99,026		326,578	100.00
101.00	UNIT COST MULTIPLIER	9.109856	0.000000	0.194634		0.282192	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	974					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	172	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	802	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	20,459	0	0	0	0	100.00
101.00	UNIT COST MULTIPLIER	21.005133	0.000000	0.000000	0.000000	0.000000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

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Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	6,023					10.00
11.00	MEDICAL RECORDS		6,023				11.00
12.00	STAFF TRANSPORTATION			100			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00	PHARMACY			0	0	6,023	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE (DELETED)			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	5,921	5,921	100	0	5,921	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	5	5	0	0	5	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	97	97	0	0	97	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	14,934	54,532	41,556	0	2,681	100.00
101.00	UNIT COST MULTIPLIER	2.479495	9.053960	415.560000	0.000000	0.445127	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0143
Hospice CCN: 14-1595

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

Worksheet O-6
Part II
Date/Time Prepared:
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Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (DELETED) (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE (DELETED)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 14-0143 Hospice CCN: 14-1595

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

Worksheet O-7

Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.263836	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.233708	0	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.332291	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.462828	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.126152	0	0	0	6.00
6.01	BLOOD LABORATORY	60.01	0.000000	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.064461	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0.000000	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	SONOGRAPHY	76.00	0.114365	0	0	0	10.00
10.01	AUDIOLOGY	76.01	0.616159	0	0	0	10.01
10.02	CARDIAC REHAB	76.02	0.311948	0	0	0	10.02
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	0	0	0	0	0	2.00
3.00	SPEECH PATHOLOGY	0	0	0	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	0	0	0	6.00
6.01	BLOOD LABORATORY	0	0	0	0	0	6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	SONOGRAPHY	0	0	0	0	0	10.00
10.01	AUDIOLOGY	0	0	0	0	0	10.01
10.02	CARDIAC REHAB	0	0	0	0	0	10.02
11.00	Totals (sum of lines 1-11)		0	0	0	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0143 | Hospice CCN: 14-1595 | Period: From 10/01/2016 To 09/30/2017 | Worksheet O-8 | Date/Time Prepared: 2/23/2018 7:38 am

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,439,332	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			5,921	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			243.09	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	5,921	0		9.00
10.00	Program cost (line 8 times line 9)	1,439,336	0		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			4,791	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			5	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			958.20	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	5	0		14.00
15.00	Program cost (line 13 times line 14)	4,791	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			39,745	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			97	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			409.74	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	97	0		19.00
20.00	Program cost (line 18 times line 19)	39,745	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,483,868	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			6,023	22.00
23.00	Average cost per diem (line 21 divided by line 22)			246.37	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0143	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/23/2018 7:38 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	588,760	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	2,488	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)	17.64	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	591,248	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