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: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/23/2018 12:39 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2018 Time: 12:39 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SAINT JAMES HOSPITAL (14-0161) 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	14,873	-13,180	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
200.00	Total	0	14,873	-13,180	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 10:01 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2500 WEST REYNOLDS STREET	PO Box:			1.00
2.00	City: PONTIAC	State: IL	Zip Code: 61764	County: LIVINGSTON	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	SAINT JAMES HOSPITAL	140161	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST JAMES HOSPITAL SWING	14U161	99914		10/10/2002	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									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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	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.	330	119	0	0	482	22	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2018 10:01 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.	1		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.	10/01/2016	09/30/2017	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 10:01 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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 10:01 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: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/23/2018 10:01 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.	N	N	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.	N	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.	N	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.	N	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.	N	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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A 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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 10:01 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:	0	0	1	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.	Y	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	149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2018 10:01 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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 06101	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	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.	N	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)			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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2018 10:01 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)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/19/2018	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/14/2018	Y	12/14/2018	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/23/2018 10:01 am

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LOUIS	RAPTOPOULOS	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309)-624-9230	LOUIS.C.RAPTOPOULO@OSFHEALTHCARE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/23/2018 10:01 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.	GOVT REIMBURSEMENT SENIOR ANALYST		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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2018 10:01 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	37	13,505	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)		37	13,505	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	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)		42	15,330	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		42				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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2018 10:01 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)	2,708	243	4,331			1.00
2.00	HMO and other (see instructions)	715	601				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	20	0	91			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)	2,728	243	4,422			7.00
8.00	INTENSIVE CARE UNIT	512	64	1,079			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		23	396			13.00
14.00	Total (see instructions)	3,240	330	5,897	0.00	274.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	274.00	27.00
28.00	Observation Bed Days		197	1,299			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	22	43			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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2018 10:01 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	882	267	1,860	1.00
2.00	HMO and other (see instructions)			222	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	882	267	1,860	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2018 10:01 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	16,629,589	166,762	16,796,351	552,790.00	30.38	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		102,093	0	102,093	717.00	142.39	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		302,776	0	302,776	754.00	401.56	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)		388,242	400	388,642	14,547.00	26.72	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,023,863	0	1,023,863	15,082.00	67.89	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		93,484	0	93,484	827.00	113.04	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		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		3,444,168	0	3,444,168	96,662.00	35.63	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)		5,332,442	0	5,332,442			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		138,845	0	138,845			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		17,279	0	17,279			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		42,762	0	42,762			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)		1,114,822	0	1,114,822			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	-23,551	24,267	716	36.00	19.89	26.00
27.00	Administrative & General	5.00	1,702,213	18,538	1,720,751	35,824.00	48.03	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/23/2018 10:01 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.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	66,996	764	67,760	2,130.00	31.81	29.00
30.00	Operation of Plant	7.00	431,498	4,924	436,422	18,750.00	23.28	30.00
31.00	Laundry & Linen Service	8.00	22,695	259	22,954	2,093.00	10.97	31.00
32.00	Housekeeping	9.00	512,258	3,501	515,759	39,757.00	12.97	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	439,997	-319,144	120,853	7,966.00	15.17	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	323,792	323,792	21,344.00	15.17	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	952,433	-183,040	769,393	20,352.00	37.80	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	380,214	4,228	384,442	15,113.00	25.44	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/23/2018 10:01 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)		16,326,813	166,762	16,493,575	552,036.00	29.88	1.00
2.00	Excluded area salaries (see instructions)		388,242	400	388,642	14,547.00	26.72	2.00
3.00	Subtotal salaries (line 1 minus line 2)		15,938,571	166,362	16,104,933	537,489.00	29.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		4,561,515	0	4,561,515	112,571.00	40.52	4.00
5.00	Subtotal wage-related costs (see inst.)		6,464,543	0	6,464,543	0.00	40.14	5.00
6.00	Total (sum of lines 3 thru 5)		26,964,629	166,362	27,130,991	650,060.00	41.74	6.00
7.00	Total overhead cost (see instructions)		4,484,753	-121,911	4,362,842	163,365.00	26.71	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/23/2018 10:01 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	818,962	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	278,108	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)	3,303,124	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	18,286	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	11,854	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	1,016,582	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	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	84,412	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,531,328	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 2/23/2018 10:01 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	1,023,863	0	1.00
2.00	Hospital	1,023,863	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 | Date/Time Prepared: 2/23/2018 10:01 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	10/10/2002	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	0	0	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	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	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	0	0	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	5	5	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	15	15	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-7 | Date/Time Prepared: 2/23/2018 10:01 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	20	20	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).	16974	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 UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet S-10 Date/Time Prepared: 2/23/2018 10:01 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)	0.198814	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,182,973	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	40,315,614	6.00
7.00	Medicaid cost (line 1 times line 6)	8,015,308	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,832,335	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,832,335	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)	3,982,159	473,732	4,455,891	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	791,709	473,732	1,265,441	21.00
22.00	Payments received from patients for amounts previously written off as charity care	60,070	61,950	122,020	22.00
23.00	Cost of charity care (line 21 minus line 22)	731,639	411,782	1,143,421	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)	3,841,740	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	225,862	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	347,481	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	3,494,259	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	816,327	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,959,748	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,792,083	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,556,442	1,556,442	30,158	1,586,600	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,723,606	1,723,606	18,381	1,741,987	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-23,551	6,398,311	6,374,760	-160,781	6,213,979	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,702,213	7,580,146	9,282,359	-29,186	9,253,173	5.00
6.00	00600	MAINTENANCE & REPAIRS	66,996	805,031	872,027	-268,293	603,734	6.00
7.00	00700	OPERATION OF PLANT	431,498	1,119,988	1,551,486	4,924	1,556,410	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,695	134,650	157,345	259	157,604	8.00
9.00	00900	HOUSEKEEPING	512,258	14,576	526,834	5,819	532,653	9.00
10.00	01000	DIETARY	439,997	142,070	582,067	-422,500	159,567	10.00
11.00	01100	CAFETERIA	0	0	0	427,516	427,516	11.00
13.00	01300	NURSING ADMINISTRATION	952,433	65,309	1,017,742	-189,825	827,917	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	380,214	7,999	388,213	4,228	392,441	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,348,136	945,959	3,294,095	-44,396	3,249,699	30.00
31.00	03100	INTENSIVE CARE UNIT	772,233	221,021	993,254	8,224	1,001,478	31.00
43.00	04300	NURSERY	0	0	0	69,841	69,841	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,704,901	2,751,023	4,455,924	-2,095,902	2,360,022	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	553,521	491,711	1,045,232	-18,198	1,027,034	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	481,614	25,491	507,105	61,123	568,228	54.00
54.10	03630	ULTRA SOUND	235,381	4,776	240,157	2,623	242,780	54.10
54.20	03440	MAMMOGRAPHY	125,011	100,114	225,125	1,388	226,513	54.20
56.00	05600	RADIOISOTOPE	81,712	121,359	203,071	17,651	220,722	56.00
57.00	05700	CT SCAN	148,076	271,628	419,704	108,232	527,936	57.00
58.00	05800	MRI	173,490	278,020	451,510	91,922	543,432	58.00
60.00	06000	LABORATORY	905,134	1,205,830	2,110,964	-128,818	1,982,146	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	138,854	138,854	63.00
64.00	06400	INTRAVENOUS THERAPY	120,784	13,987	134,771	1,344	136,115	64.00
65.00	06500	RESPIRATORY THERAPY	329,876	65,953	395,829	-34,961	360,868	65.00
66.00	06600	PHYSICAL THERAPY	573,522	16,454	589,976	103,974	693,950	66.00
67.00	06700	OCCUPATIONAL THERAPY	220,626	5,270	225,896	36,652	262,548	67.00
68.00	06800	SPEECH PATHOLOGY	207,691	90,511	298,202	51,673	349,875	68.00
69.00	06900	ELECTROCARDIOLOGY	221,099	15,856	236,955	2,468	239,423	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	233,467	88,563	322,030	2,626	324,656	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	82,487	55,596	138,083	670,379	808,462	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,481,179	1,481,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	526,860	1,982,048	2,508,908	56,224	2,565,132	73.00
76.00	03950	DIABETES SERVICES	62,510	869	63,379	697	64,076	76.00
76.97	07697	CARDIAC REHABILITATION	91,365	1,007	92,372	1,020	93,392	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,557,098	2,182,331	3,739,429	-6,919	3,732,510	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,241,347	30,483,505	46,724,852	-400	46,724,452	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,620	11,090	32,710	247	32,957	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	341,697	151,613	493,310	-131	493,179	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	15,773	399,114	414,887	180	415,067	192.02
192.03	19203	PULMONARY FUNCTION	9,152	401	9,553	104	9,657	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	16,629,589	31,045,723	47,675,312	0	47,675,312	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	133,679	1,720,279		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	177,840	1,919,827		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-166,766	6,047,213		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,605,423	6,647,750		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	603,734		6.00
7.00	00700	OPERATION OF PLANT	-23,667	1,532,743		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	157,604		8.00
9.00	00900	HOUSEKEEPING	0	532,653		9.00
10.00	01000	DIETARY	-21,600	137,967		10.00
11.00	01100	CAFETERIA	-144,970	282,546		11.00
13.00	01300	NURSING ADMINISTRATION	-740	827,177		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-22,569	369,872		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,030	3,248,669		30.00
31.00	03100	INTENSIVE CARE UNIT	-16,993	984,485		31.00
43.00	04300	NURSERY	0	69,841		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,360,022		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-597,503	429,531		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,142	567,086		54.00
54.10	03630	ULTRA SOUND	0	242,780		54.10
54.20	03440	MAMMOGRAPHY	0	226,513		54.20
56.00	05600	RADIOISOTOPE	-337	220,385		56.00
57.00	05700	CT SCAN	15,452	543,388		57.00
58.00	05800	MRI	-1,810	541,622		58.00
60.00	06000	LABORATORY	-3,784	1,978,362		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	138,854		63.00
64.00	06400	INTRAVENOUS THERAPY	0	136,115		64.00
65.00	06500	RESPIRATORY THERAPY	0	360,868		65.00
66.00	06600	PHYSICAL THERAPY	-150	693,800		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	262,548		67.00
68.00	06800	SPEECH PATHOLOGY	-917	348,958		68.00
69.00	06900	ELECTROCARDIOLOGY	0	239,423		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-11	324,645		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-7,209	801,253		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,481,179		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,056	2,584,188		73.00
76.00	03950	DIABETES SERVICES	-25	64,051		76.00
76.97	07697	CARDIAC REHABILITATION	-13,690	79,702		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	-1,955,589	1,776,921		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,239,898	41,484,554		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32,957		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	493,179		192.00
192.01	19201	CARDIAC PHASE III	0	0		192.01
192.02	19202	FUND DEVELOPMENT	0	415,067		192.02
192.03	19203	PULMONARY FUNCTION	0	9,657		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,239,898	42,435,414		200.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/23/2018 10:01 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TEAM AWARD RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	24,259	0	1.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		24,259	0	
	B - PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	48,539	1.00
	0		0	48,539	
	C - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	320,407	103,456	1.00
	0		320,407	103,456	
	D - BLOOD				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	12,037	1.00
2.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	126,817	2.00
	0		0	138,854	
	E - REHAB ADMIN RECLASS				
1.00	PHYSICAL THERAPY	66.00	92,935	3,594	1.00
2.00	OCCUPATIONAL THERAPY	67.00	35,584	1,376	2.00
3.00	SPEECH PATHOLOGY	68.00	46,974	1,815	3.00
	0		175,493	6,785	
	G - IMPLANT DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,481,179	1.00
2.00		0.00	0	0	2.00
	0		0	1,481,179	
	H - MED SUPPLIES CHARGED TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	669,445	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	0		0	669,445	
	I - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	50,212	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	50,212	
	J - DISABILITY				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	815	1.00
2.00	HOUSEKEEPING	9.00	0	2,318	2.00
3.00	DIETARY	10.00	0	100	3.00
4.00	CAFETERIA	11.00	0	268	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	4,921	5.00
6.00	OPERATING ROOM	50.00	0	628	6.00
7.00	ULTRA SOUND	54.10	0	1,209	7.00
8.00	LABORATORY	60.00	0	2,935	8.00
9.00	INTRAVENOUS THERAPY	64.00	0	1,603	9.00
10.00	EMERGENCY	91.00	0	3,489	10.00
	0		0	18,286	

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		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - NURSERY COST					
1.00	NURSERY	43.00	64,160	5,681		1.00
	TOTALS		64,160	5,681		
	L - TO RECLASS SFI RELATED PARTY COST					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	55,754		1.00
2.00	RADIOISOTOPE	56.00	0	16,735		2.00
3.00	CT SCAN	57.00	0	106,576		3.00
4.00	MRI	58.00	0	89,992		4.00
	TOTALS		0	269,057		
	Z - VACATION ACCRUAL RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	8	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	19,543	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	764	0		3.00
4.00	OPERATION OF PLANT	7.00	4,924	0		4.00
5.00	LAUNDRY & LINEN SERVICE	8.00	259	0		5.00
6.00	HOUSEKEEPING	9.00	5,819	0		6.00
7.00	DIETARY	10.00	1,363	0		7.00
8.00	CAFETERIA	11.00	3,653	0		8.00
9.00	NURSING ADMINISTRATION	13.00	8,680	0		9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	4,337	0		10.00
11.00	ADULTS & PEDIATRICS	30.00	26,006	0		11.00
12.00	INTENSIVE CARE UNIT	31.00	8,810	0		12.00
13.00	OPERATING ROOM	50.00	19,442	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	5,494	0		14.00
15.00	ULTRA SOUND	54.10	2,672	0		15.00
16.00	MAMMOGRAPHY	54.20	1,426	0		16.00
17.00	RADIOISOTOPE	56.00	932	0		17.00
18.00	CT SCAN	57.00	1,689	0		18.00
19.00	MRI	58.00	1,979	0		19.00
20.00	LABORATORY	60.00	10,292	0		20.00
21.00	INTRAVENOUS THERAPY	64.00	1,360	0		21.00
22.00	RESPIRATORY THERAPY	65.00	3,763	0		22.00
23.00	PHYSICAL THERAPY	66.00	7,603	0		23.00
24.00	OCCUPATIONAL THERAPY	67.00	2,923	0		24.00
25.00	SPEECH PATHOLOGY	68.00	2,906	0		25.00
26.00	ELECTROCARDIOLOGY	69.00	2,522	0		26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	2,664	0		27.00
28.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	941	0		28.00
29.00	DRUGS CHARGED TO PATIENTS	73.00	6,012	0		29.00
30.00	DIABETES SERVICES	76.00	713	0		30.00
31.00	CARDIAC REHABILITATION	76.97	1,042	0		31.00
32.00	EMERGENCY	91.00	17,660	0		32.00
33.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	247	0		33.00
34.00	FUND DEVELOPMENT	192.02	180	0		34.00
35.00	PULMONARY FUNCTION	192.03	104	0		35.00
36.00	ANESTHESIOLOGY	53.00	6,316	0		36.00
37.00		0.00	0	0		37.00
	0		185,048	0		
500.00	Grand Total: Increases		769,367	2,791,494		500.00

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/23/2018 10:01 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - TEAM AWARD RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	190	0	0	1.00
4.00	NURSING ADMINISTRATION	13.00	16,227	0	0	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	109	0	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	141	0	0	6.00
7.00	OPERATING ROOM	50.00	446	0	0	7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	125	0	0	8.00
9.00	ULTRA SOUND	54.10	49	0	0	9.00
10.00	MAMMOGRAPHY	54.20	38	0	0	10.00
11.00	RADIOISOTOPE	56.00	16	0	0	11.00
12.00	CT SCAN	57.00	33	0	0	12.00
13.00	MRI	58.00	49	0	0	13.00
14.00	LABORATORY	60.00	256	0	0	14.00
15.00	INTRAVENOUS THERAPY	64.00	16	0	0	15.00
16.00	RESPIRATORY THERAPY	65.00	87	0	0	16.00
17.00	PHYSICAL THERAPY	66.00	158	0	0	17.00
18.00	OCCUPATIONAL THERAPY	67.00	65	0	0	18.00
19.00	SPEECH PATHOLOGY	68.00	22	0	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	54	0	0	20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	38	0	0	21.00
22.00	DIABETES SERVICES	76.00	16	0	0	22.00
23.00	CARDIAC REHABILITATION	76.97	22	0	0	23.00
24.00	EMERGENCY	91.00	5,971	0	0	24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	131	0	0	25.00
	0		24,259	0		
	B - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	48,539	12	1.00
	0		0	48,539		
	C - CAFETERIA RECLASS					
1.00	DIETARY	10.00	320,407	103,456	0	1.00
	0		320,407	103,456		
	D - BLOOD					
1.00	LABORATORY	60.00	0	138,854	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	138,854		
	E - REHAB ADMIN RECLASS					
1.00	NURSING ADMINISTRATION	13.00	175,493	6,785	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	0		175,493	6,785		
	G - IMPLANT DEVICE					
1.00	OPERATING ROOM	50.00	0	1,481,172	0	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7	0	2.00
	0		0	1,481,179		
	H - MED SUPPLIES CHARGED TO PATIENTS					
1.00	OPERATING ROOM	50.00	0	627,642	0	1.00
3.00	RESPIRATORY THERAPY	65.00	0	38,637	0	3.00
4.00	OCCUPATIONAL THERAPY	67.00	0	3,166	0	4.00
	0		0	669,445		
	I - DRUGS CHARGED TO PATIENTS					
1.00	ADULTS & PEDIATRICS	30.00	0	561	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	445	0	2.00
3.00	OPERATING ROOM	50.00	0	6,084	0	3.00
4.00	ANESTHESIOLOGY	53.00	0	24,514	0	4.00
5.00	EMERGENCY	91.00	0	18,608	0	5.00
	0		0	50,212		
	J - DISABILITY					
1.00	ADMINISTRATIVE & GENERAL	5.00	815	0	0	1.00
2.00	HOUSEKEEPING	9.00	2,318	0	0	2.00
3.00	DIETARY	10.00	100	0	0	3.00
4.00	CAFETERIA	11.00	268	0	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	4,921	0	0	5.00
6.00	OPERATING ROOM	50.00	628	0	0	6.00
7.00	ULTRA SOUND	54.10	1,209	0	0	7.00
8.00	LABORATORY	60.00	2,935	0	0	8.00
9.00	INTRAVENOUS THERAPY	64.00	1,603	0	0	9.00
10.00	EMERGENCY	91.00	3,489	0	0	10.00
	0		18,286	0		
	K - NURSERY COST					
1.00	ADULTS & PEDIATRICS	30.00	64,160	5,681	0	1.00
	TOTALS		64,160	5,681		

RECLASSIFICATIONS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/23/2018 10:01 am

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	L - TO RECLASS SFI RELATED PARTY COST					
1.00	MAINTENANCE & REPAIRS	6.00	0	269,057	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
	TOTALS		0	269,057		
	Z - VACATION ACCRUAL RECLASS					
1.00		0.00	0	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
32.00		0.00	0	0	0	32.00
33.00		0.00	0	0	0	33.00
34.00		0.00	0	0	0	34.00
35.00		0.00	0	0	0	35.00
36.00		0.00	0	0	0	36.00
37.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	185,048	0	37.00
	0		0	185,048		
500.00	Grand Total: Decreases		602,605	2,958,256		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2018 10:01 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	600,013	0	0	0	0	1.00
2.00	Land Improvements	2,390,475	0	0	0	10,060	2.00
3.00	Buildings and Fixtures	38,137,420	577,934	0	577,934	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	24,066,971	1,396,839	0	1,396,839	1,934,084	5.00
6.00	Movable Equipment	67,172	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,262,051	1,974,773	0	1,974,773	1,944,144	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,262,051	1,974,773	0	1,974,773	1,944,144	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	600,013	0	1.00
2.00	Land Improvements	2,380,415	0	2.00
3.00	Buildings and Fixtures	38,715,354	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	23,529,726	0	5.00
6.00	Movable Equipment	67,172	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,292,680	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	65,292,680	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2018 10:01 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,556,442	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,723,606	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,280,048	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	1,556,442		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,723,606		2.00
3.00	Total (sum of lines 1-2)	0	3,280,048		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III | Date/Time Prepared: 2/23/2018 10:01 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,715,354	0	38,715,354	0.621312	30,158	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,596,898	0	23,596,898	0.378688	18,381	2.00
3.00	Total (sum of lines 1-2)	62,312,252	0	62,312,252	1.000000	48,539	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	30,158	1,690,121	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	18,381	1,901,446	0	2.00
3.00	Total (sum of lines 1-2)	0	0	48,539	3,591,567	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	30,158	0	0	1,720,279	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,381	0	0	1,919,827	2.00
3.00	Total (sum of lines 1-2)	0	48,539	0	0	3,640,106	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/23/2018 10:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,375,722			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	-378,914			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-133,155	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	-369	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-22,569	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	B	-11,815	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-63,220	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		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	HOSPITAL ADMINISTRATION	B	-4,440	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/23/2018 10:01 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	LOBBYING DUES INCLUDING AHA AND IHA	A	-20,446	ADMINISTRATIVE & GENERAL	5.00	0	34.00
36.00	PRE EMPLOYMENT PHYSICALS	A	-16,388	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
37.00	PRE EMPLOYMENT PHYSICALS	B	-30	ADULTS & PEDIATRICS	30.00	0	37.00
38.00	EMERGENCY MEDICAL TRANSPORTATIO	B	-47,898	EMERGENCY	91.00	0	38.00
39.00	LAB NON PATIENT INCOME	B	-705	LABORATORY	60.00	0	39.00
39.01	CARDIAC REHAB	B	-12,300	CARDIAC REHABILITATION	76.97	0	39.01
40.00	RADIOLOGY - SILVER RECOVERY & F	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	40.00
41.00	PEDIATRIC DEVELOPMENT	B	-39	PHYSICAL THERAPY	66.00	0	41.00
42.00	AUDIOLOGY	B	-917	SPEECH PATHOLOGY	68.00	0	42.00
43.00	EMPLOYEE BENEFIT OFFSET - GEN & ADMI	A	-8,568	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	SLEEP CENTER PROPERTY	B	-3,823	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	HOSPITAL ADMIN - FARM INCOME &	B	-30,803	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	REYNOLDS STREET PROPERTY - RENT	B	-16,204	ADMINISTRATIVE & GENERAL	5.00	0	46.00
47.00	CHAPLAINCY - CANDLES & RENTAL I	B	-12,513	ADMINISTRATIVE & GENERAL	5.00	0	47.00
49.00	INSERVICE EDUC - NURSING CLASS	B	-740	NURSING ADMINISTRATION	13.00	0	49.00
49.01	DIABETES SERVICES	B	-25	DIABETES SERVICES	76.00	0	49.01
49.02	CABLE	A	-11,592	OPERATION OF PLANT	7.00	0	49.02
49.03	PART B EMPLOYEE BENEFIT OFFSET	A	-67,742	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.03
49.04	SFMC SHARED LABOR EMPLOYEE BENEFITS	A	-275,891	EMERGENCY	91.00	0	49.04
49.05	340B PAYBACK	A	51,297	DRUGS CHARGED TO PATIENTS	73.00	0	49.05
49.11	DIETARY O/P REVENUE	B	-21,420	DIETARY	10.00	0	49.11
49.12	MEDICAID ASSESSMENT	A	-1,752,516	ADMINISTRATIVE & GENERAL	5.00	0	49.12
49.13	REVENUE CYCLE ADMINISTRATION	B	-120	ADMINISTRATIVE & GENERAL	5.00	0	49.13
49.15	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.15
49.16	SJJWAMC-PEDS DEVELOMENT CTR	B	-111	PHYSICAL THERAPY	66.00	0	49.16
49.17	DIETARY	B	-180	DIETARY	10.00	0	49.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,239,898				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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2018 10:01 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	1.00	CAP REL COSTS-BLDG & FIXT	CORP OFFICE CHARGES - BLDG D	133,679	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFFICE CHARGES - EQUIP	807,846	630,006	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	CORP OFFICE CHARGES	729,985	812,621	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	4,874,716	5,426,547	3.01
3.02	7.00	OPERATION OF PLANT	CORP OFFICE CHARGES	106,664	118,739	3.02
4.00	31.00	INTENSIVE CARE UNIT	CORP OFFICE CHARGES - EICU	150,116	167,109	4.00
4.01	71.00	MEDICAL SUPPLIES CHARGED TO	CORP OFFICE CHARGES	63,680	70,889	4.01
4.02	73.00	DRUGS CHARGED TO PATIENTS	CORP OFFICE CHARGES - E-PHAR	281,549	313,421	4.02
4.03	60.00	LABORATORY	SYSTEMS LAB	586,026	586,026	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	SFI PURCHASE MAINT & SVC	54,632	55,754	4.04
4.05	56.00	RADIOISOTOPE	SFI PURCHASE MAINT & SVC	16,398	16,735	4.05
4.06	57.00	CT SCAN	SFI PURCHASE MAINT & SVC	104,432	106,576	4.06
4.07	58.00	MRI	SFI PURCHASE MAINT & SVC	88,182	89,992	4.07
4.08	57.00	CT SCAN	PET SCAN	48,656	31,060	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,046,561	8,425,475	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	OSF HEALTHCARE SYSTEM	100.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/23/2018 10:01 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	133,679	9		1.00
2.00	177,840	9		2.00
3.00	-82,636	0		3.00
3.01	-551,831	0		3.01
3.02	-12,075	0		3.02
4.00	-16,993	0		4.00
4.01	-7,209	0		4.01
4.02	-31,872	0		4.02
4.03	0	0		4.03
4.04	-1,122	0		4.04
4.05	-337	0		4.05
4.06	-2,144	0		4.06
4.07	-1,810	0		4.07
4.08	17,596	0		4.08
5.00	-378,914			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	CATHOLIC SYSTEM		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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2018 10:01 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	5.00	ADMINISTRATIVE & GENERAL	172,899	122,500	50,399	159,800	416	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,000	1,000	0	200,300	0	2.00
3.00	53.00	ANESTHESIOLOGY	657,497	543,678	113,819	167,500	745	3.00
4.00	60.00	LABORATORY	3,079	3,079	0	208,000	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	8,846	0	8,846	159,800	115	5.00
6.00	76.97	CARDIAC REHABILITATION	6,000	0	6,000	159,800	60	6.00
7.00	91.00	EMERGENCY	1,647,780	1,617,780	30,000	159,800	208	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,497,101	2,288,037	209,064		1,544	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	31,960	1,598	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	59,994	3,000	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	8,835	442	0	0	0	5.00
6.00	76.97	CARDIAC REHABILITATION	4,610	231	0	0	0	6.00
7.00	91.00	EMERGENCY	15,980	799	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			121,379	6,070	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	31,960	18,439	140,939		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,000		2.00
3.00	53.00	ANESTHESIOLOGY	0	59,994	53,825	597,503		3.00
4.00	60.00	LABORATORY	0	0	0	3,079		4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	8,835	11	11		5.00
6.00	76.97	CARDIAC REHABILITATION	0	4,610	1,390	1,390		6.00
7.00	91.00	EMERGENCY	0	15,980	14,020	1,631,800		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	121,379	87,685	2,375,722		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,720,279	1,720,279				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,919,827		1,919,827			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,047,213	0	0	6,047,213		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,647,750	441,532	1,160,164	619,551	8,868,997	5.00
6.00	00600	MAINTENANCE & REPAIRS	603,734	11,694	2,907	24,397	642,732	6.00
7.00	00700	OPERATION OF PLANT	1,532,743	110,882	89,509	157,132	1,890,266	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	157,604	7,590	0	8,265	173,459	8.00
9.00	00900	HOUSEKEEPING	532,653	32,498	15,110	185,697	765,958	9.00
10.00	01000	DIETARY	137,967	8,784	2,240	43,513	192,504	10.00
11.00	01100	CAFETERIA	282,546	35,039	6,000	116,580	440,165	11.00
13.00	01300	NURSING ADMINISTRATION	827,177	3,160	31,134	277,018	1,138,489	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	369,872	19,338	0	138,417	527,627	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,248,669	167,854	87,602	829,924	4,334,049	30.00
31.00	03100	INTENSIVE CARE UNIT	984,485	30,174	45,538	281,161	1,341,358	31.00
43.00	04300	NURSERY	69,841	3,865	4,741	23,101	101,548	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,360,022	207,377	172,182	620,458	3,360,039	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	429,531	0	28,104	201,568	659,203	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	567,086	49,100	53,650	175,337	845,173	54.00
54.10	03630	ULTRA SOUND	242,780	3,127	3,413	85,257	334,577	54.10
54.20	03440	MAMMOGRAPHY	226,513	4,886	1,166	45,510	278,075	54.20
56.00	05600	RADIOISOTOPE	220,385	532	77,945	29,750	328,612	56.00
57.00	05700	CT SCAN	543,388	7,839	5,516	53,911	610,654	57.00
58.00	05800	MRI	541,622	13,388	0	63,159	618,169	58.00
60.00	06000	LABORATORY	1,978,362	24,213	30,506	328,448	2,361,529	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	138,854	0	0	0	138,854	63.00
64.00	06400	INTRAVENOUS THERAPY	136,115	0	0	43,394	179,509	64.00
65.00	06500	RESPIRATORY THERAPY	360,868	4,539	2,465	120,094	487,966	65.00
66.00	06600	PHYSICAL THERAPY	693,800	48,058	19,207	242,636	1,003,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	262,548	14,865	1,342	93,277	372,032	67.00
68.00	06800	SPEECH PATHOLOGY	348,958	22,270	5,210	92,730	469,168	68.00
69.00	06900	ELECTROCARDIOLOGY	239,423	2,519	10,441	80,495	332,878	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	324,645	0	15,478	85,005	425,128	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	801,253	23,909	6,300	30,038	861,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,481,179	0	0	0	1,481,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,584,188	11,053	5,895	191,859	2,792,995	73.00
76.00	03950	DIABETES SERVICES	64,051	1,118	0	22,757	87,926	76.00
76.97	07697	CARDIAC REHABILITATION	79,702	14,810	8,409	33,263	136,184	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	1,776,921	67,830	27,653	563,581	2,435,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,484,554	1,393,843	1,919,827	5,907,283	41,018,188	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,957	57,928	0	7,873	98,758	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	493,179	245,891	0	122,980	862,050	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	415,067	22,617	0	5,744	443,428	192.02
192.03	19203	PULMONARY FUNCTION	9,657	0	0	3,333	12,990	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,435,414	1,720,279	1,919,827	6,047,213	42,435,414	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,868,997					5.00
6.00	00600	MAINTENANCE & REPAIRS	169,824	812,556				6.00
7.00	00700	OPERATION OF PLANT	499,450	71,109	2,460,825			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,832	4,867	16,154	240,312		8.00
9.00	00900	HOUSEKEEPING	202,383	20,841	69,170	0	1,058,352	9.00
10.00	01000	DIETARY	50,864	5,633	18,697	12	8,330	10.00
11.00	01100	CAFETERIA	116,301	22,470	74,578	32	33,227	11.00
13.00	01300	NURSING ADMINISTRATION	300,814	2,026	6,725	0	2,996	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,411	12,402	41,160	0	18,338	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,145,161	107,645	357,268	76,337	159,173	30.00
31.00	03100	INTENSIVE CARE UNIT	354,416	19,351	64,225	12,082	28,614	31.00
43.00	04300	NURSERY	26,831	2,472	8,204	1,209	3,655	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	887,796	132,991	441,391	60,402	196,652	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	174,176	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	223,313	31,488	104,506	25,712	46,561	54.00
54.10	03630	ULTRA SOUND	88,403	2,005	6,656	0	2,965	54.10
54.20	03440	MAMMOGRAPHY	73,474	3,133	10,400	0	4,633	54.20
56.00	05600	RADIOISOTOPE	86,827	341	1,132	0	505	56.00
57.00	05700	CT SCAN	161,348	5,027	16,686	0	7,434	57.00
58.00	05800	MRI	163,334	8,586	28,495	0	12,696	58.00
60.00	06000	LABORATORY	623,968	15,528	51,537	0	22,961	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	36,688	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	47,430	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	128,931	2,911	9,660	0	4,304	65.00
66.00	06600	PHYSICAL THERAPY	265,200	30,819	102,288	4,454	45,572	66.00
67.00	06700	OCCUPATIONAL THERAPY	98,299	9,533	31,639	0	14,096	67.00
68.00	06800	SPEECH PATHOLOGY	123,965	14,282	47,400	0	21,118	68.00
69.00	06900	ELECTROCARDIOLOGY	87,954	1,615	5,362	0	2,389	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	112,328	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	227,627	15,333	50,890	0	22,673	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	391,360	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	737,971	7,089	23,527	0	10,482	73.00
76.00	03950	DIABETES SERVICES	23,232	717	2,380	0	1,061	76.00
76.97	07697	CARDIAC REHABILITATION	35,983	9,498	31,523	0	14,044	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	643,641	43,499	144,372	59,123	64,322	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,494,535	603,211	1,766,025	239,363	748,801	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	26,094	37,149	123,295	0	54,932	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	227,773	157,692	523,365	949	233,171	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	117,163	14,504	48,140	0	21,448	192.02
192.03	19203	PULMONARY FUNCTION	3,432	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,868,997	812,556	2,460,825	240,312	1,058,352	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	276,040					10.00
11.00	01100	CAFETERIA	0	686,773				11.00
13.00	01300	NURSING ADMINISTRATION	0	33,018	1,484,068			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,113	0	762,051		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	219,973	132,367	566,631	44,127	7,142,731	30.00
31.00	03100	INTENSIVE CARE UNIT	44,691	33,018	141,340	13,782	2,052,877	31.00
43.00	04300	NURSERY	1,185	3,005	12,862	2,117	163,088	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,191	92,450	395,751	86,361	5,664,024	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	3,302	0	12,259	848,940	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	26,414	0	25,864	1,329,031	54.00
54.10	03630	ULTRA SOUND	0	9,905	0	17,349	461,860	54.10
54.20	03440	MAMMOGRAPHY	0	6,604	0	10,145	386,464	54.20
56.00	05600	RADIOISOTOPE	0	3,302	0	12,335	433,054	56.00
57.00	05700	CT SCAN	0	6,604	0	82,830	890,583	57.00
58.00	05800	MRI	0	9,905	0	34,748	875,933	58.00
60.00	06000	LABORATORY	0	62,734	0	138,006	3,276,263	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,323	177,865	63.00
64.00	06400	INTRAVENOUS THERAPY	0	6,604	0	2,986	236,529	64.00
65.00	06500	RESPIRATORY THERAPY	0	19,811	0	10,261	663,844	65.00
66.00	06600	PHYSICAL THERAPY	0	34,966	0	12,376	1,499,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,919	0	9,005	546,523	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,547	0	3,280	691,760	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,207	0	23,373	466,778	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,207	0	10,785	561,448	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	32,967	1,210,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	35,092	1,907,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,509	0	74,488	3,663,061	73.00
76.00	03950	DIABETES SERVICES	0	3,302	14,134	541	133,293	76.00
76.97	07697	CARDIAC REHABILITATION	0	6,604	0	2,088	235,924	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	82,545	353,350	62,563	3,889,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	276,040	666,962	1,484,068	762,051	39,409,270	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	340,228	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	19,811	0	0	2,024,811	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	0	0	0	644,683	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	16,422	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	276,040	686,773	1,484,068	762,051	42,435,414	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	7,142,731		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,052,877		31.00
43.00	04300	NURSERY	0	163,088		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,664,024		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	848,940		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,329,031		54.00
54.10	03630	ULTRA SOUND	0	461,860		54.10
54.20	03440	MAMMOGRAPHY	0	386,464		54.20
56.00	05600	RADIOISOTOPE	0	433,054		56.00
57.00	05700	CT SCAN	0	890,583		57.00
58.00	05800	MRI	0	875,933		58.00
60.00	06000	LABORATORY	0	3,276,263		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	177,865		63.00
64.00	06400	INTRAVENOUS THERAPY	0	236,529		64.00
65.00	06500	RESPIRATORY THERAPY	0	663,844		65.00
66.00	06600	PHYSICAL THERAPY	0	1,499,376		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	546,523		67.00
68.00	06800	SPEECH PATHOLOGY	0	691,760		68.00
69.00	06900	ELECTROCARDIOLOGY	0	466,778		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	561,448		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,210,990		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,907,631		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,663,061		73.00
76.00	03950	DIABETES SERVICES	0	133,293		76.00
76.97	07697	CARDIAC REHABILITATION	0	235,924		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	3,889,400		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	39,409,270		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	340,228		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,024,811		192.00
192.01	19201	CARDIAC PHASE III	0	0		192.01
192.02	19202	FUND DEVELOPMENT	0	644,683		192.02
192.03	19203	PULMONARY FUNCTION	0	16,422		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	42,435,414		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	90,893	441,532	1,160,164	1,692,589	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	11,694	2,907	14,601	0	6.00
7.00	00700	OPERATION OF PLANT	4,026	110,882	89,509	204,417	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,590	0	7,590	0	8.00
9.00	00900	HOUSEKEEPING	0	32,498	15,110	47,608	0	9.00
10.00	01000	DIETARY	0	8,784	2,240	11,024	0	10.00
11.00	01100	CAFETERIA	0	35,039	6,000	41,039	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,160	31,134	34,294	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,338	0	19,338	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,022	167,854	87,602	262,478	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,174	45,538	75,712	0	31.00
43.00	04300	NURSERY	9	3,865	4,741	8,615	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,893	207,377	172,182	452,452	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	28,104	28,104	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	49,100	53,650	102,750	0	54.00
54.10	03630	ULTRA SOUND	0	3,127	3,413	6,540	0	54.10
54.20	03440	MAMMOGRAPHY	69,839	4,886	1,166	75,891	0	54.20
56.00	05600	RADIOISOTOPE	0	532	77,945	78,477	0	56.00
57.00	05700	CT SCAN	93,000	7,839	5,516	106,355	0	57.00
58.00	05800	MRI	257,218	13,388	0	270,606	0	58.00
60.00	06000	LABORATORY	95,388	24,213	30,506	150,107	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,178	4,539	2,465	12,182	0	65.00
66.00	06600	PHYSICAL THERAPY	0	48,058	19,207	67,265	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,865	1,342	16,207	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	22,270	5,210	27,480	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,519	10,441	12,960	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61,991	0	15,478	77,469	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,909	6,300	30,209	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	51,227	11,053	5,895	68,175	0	73.00
76.00	03950	DIABETES SERVICES	0	1,118	0	1,118	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	14,810	8,409	23,219	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	67,830	27,653	95,483	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	808,684	1,393,843	1,919,827	4,122,354	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,928	0	57,928	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,218	245,891	0	265,109	0	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	22,617	0	22,617	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	827,902	1,720,279	1,919,827	4,468,008	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,692,589					5.00
6.00	00600	MAINTENANCE & REPAIRS	32,410	47,011				6.00
7.00	00700	OPERATION OF PLANT	95,317	4,114	303,848			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,747	282	1,995	18,614		8.00
9.00	00900	HOUSEKEEPING	38,623	1,206	8,541	0	95,978	9.00
10.00	01000	DIETARY	9,707	326	2,309	1	755	10.00
11.00	01100	CAFETERIA	22,195	1,300	9,208	2	3,013	11.00
13.00	01300	NURSING ADMINISTRATION	57,408	117	830	0	272	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,606	718	5,082	0	1,663	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	218,545	6,228	44,113	5,911	14,435	30.00
31.00	03100	INTENSIVE CARE UNIT	67,638	1,120	7,930	936	2,595	31.00
43.00	04300	NURSERY	5,121	143	1,013	94	331	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	169,430	7,694	54,500	4,679	17,834	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	33,240	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,618	1,822	12,904	1,992	4,222	54.00
54.10	03630	ULTRA SOUND	16,871	116	822	0	269	54.10
54.20	03440	MAMMOGRAPHY	14,022	181	1,284	0	420	54.20
56.00	05600	RADIOISOTOPE	16,570	20	140	0	46	56.00
57.00	05700	CT SCAN	30,792	291	2,060	0	674	57.00
58.00	05800	MRI	31,171	497	3,518	0	1,151	58.00
60.00	06000	LABORATORY	119,080	898	6,363	0	2,082	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,002	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	9,052	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	24,606	168	1,193	0	390	65.00
66.00	06600	PHYSICAL THERAPY	50,612	1,783	12,630	345	4,133	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,760	552	3,907	0	1,278	67.00
68.00	06800	SPEECH PATHOLOGY	23,658	826	5,853	0	1,915	68.00
69.00	06900	ELECTROCARDIOLOGY	16,785	93	662	0	217	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,437	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,441	887	6,284	0	2,056	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	74,688	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	140,837	410	2,905	0	951	73.00
76.00	03950	DIABETES SERVICES	4,434	41	294	0	96	76.00
76.97	07697	CARDIAC REHABILITATION	6,867	550	3,892	0	1,274	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	122,835	2,517	17,826	4,580	5,833	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,621,125	34,900	218,058	18,540	67,905	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,980	2,149	15,224	0	4,982	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,469	9,123	64,622	74	21,146	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	22,360	839	5,944	0	1,945	192.02
192.03	19203	PULMONARY FUNCTION	655	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,692,589	47,011	303,848	18,614	95,978	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
			10.00	11.00	13.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	24,122					10.00
11.00	01100	CAFETERIA	0	76,757				11.00
13.00	01300	NURSING ADMINISTRATION	0	3,690	96,611			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,583	0	55,990		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,222	14,796	36,887	3,237	625,852	30.00
31.00	03100	INTENSIVE CARE UNIT	3,905	3,690	9,201	1,011	173,738	31.00
43.00	04300	NURSERY	104	336	837	155	16,749	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	891	10,333	25,763	6,336	749,912	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	369	0	899	62,612	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,952	0	1,897	171,157	54.00
54.10	03630	ULTRA SOUND	0	1,107	0	1,273	26,998	54.10
54.20	03440	MAMMOGRAPHY	0	738	0	744	93,280	54.20
56.00	05600	RADIOISOTOPE	0	369	0	905	96,527	56.00
57.00	05700	CT SCAN	0	738	0	6,076	146,986	57.00
58.00	05800	MRI	0	1,107	0	2,549	310,599	58.00
60.00	06000	LABORATORY	0	7,011	0	10,210	295,751	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	170	7,172	63.00
64.00	06400	INTRAVENOUS THERAPY	0	738	0	219	10,009	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,214	0	753	41,506	65.00
66.00	06600	PHYSICAL THERAPY	0	3,908	0	908	141,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,332	0	661	42,697	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,402	0	241	61,375	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,476	0	1,715	33,908	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,476	0	791	101,173	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,419	85,296	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,574	77,262	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,845	0	5,464	220,587	73.00
76.00	03950	DIABETES SERVICES	0	369	920	40	7,312	76.00
76.97	07697	CARDIAC REHABILITATION	0	738	0	153	36,693	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	9,226	23,003	4,590	285,893	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,122	74,543	96,611	55,990	3,922,628	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	85,263	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,214	0	0	405,757	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	0	0	0	0	53,705	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	655	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	24,122	76,757	96,611	55,990	4,468,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	625,852		30.00
31.00	03100	INTENSIVE CARE UNIT	0	173,738		31.00
43.00	04300	NURSERY	0	16,749		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	749,912		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	62,612		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,157		54.00
54.10	03630	ULTRA SOUND	0	26,998		54.10
54.20	03440	MAMMOGRAPHY	0	93,280		54.20
56.00	05600	RADIOISOTOPE	0	96,527		56.00
57.00	05700	CT SCAN	0	146,986		57.00
58.00	05800	MRI	0	310,599		58.00
60.00	06000	LABORATORY	0	295,751		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	7,172		63.00
64.00	06400	INTRAVENOUS THERAPY	0	10,009		64.00
65.00	06500	RESPIRATORY THERAPY	0	41,506		65.00
66.00	06600	PHYSICAL THERAPY	0	141,584		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,697		67.00
68.00	06800	SPEECH PATHOLOGY	0	61,375		68.00
69.00	06900	ELECTROCARDIOLOGY	0	33,908		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	101,173		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	85,296		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	77,262		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	220,587		73.00
76.00	03950	DIABETES SERVICES	0	7,312		76.00
76.97	07697	CARDIAC REHABILITATION	0	36,693		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	285,893		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,922,628		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	85,263		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	405,757		192.00
192.01	19201	CARDIAC PHASE III	0	0		192.01
192.02	19202	FUND DEVELOPMENT	0	53,705		192.02
192.03	19203	PULMONARY FUNCTION	0	655		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,468,008		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	158,434					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,830,729				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	16,795,636			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	40,664	1,106,319	1,720,751	-8,868,997	33,566,417	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,077	2,772	67,760	0	642,732	6.00
7.00	00700	OPERATION OF PLANT	10,212	85,355	436,422	0	1,890,266	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	699	0	22,954	0	173,459	8.00
9.00	00900	HOUSEKEEPING	2,993	14,409	515,759	0	765,958	9.00
10.00	01000	DIETARY	809	2,136	120,853	0	192,504	10.00
11.00	01100	CAFETERIA	3,227	5,722	323,792	0	440,165	11.00
13.00	01300	NURSING ADMINISTRATION	291	29,689	769,393	0	1,138,489	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,781	0	384,442	0	527,627	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,459	83,536	2,305,062	0	4,334,049	30.00
31.00	03100	INTENSIVE CARE UNIT	2,779	43,425	780,902	0	1,341,358	31.00
43.00	04300	NURSERY	356	4,521	64,160	0	101,548	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,099	164,191	1,723,269	0	3,360,039	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	26,800	559,837	0	659,203	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,522	51,160	486,983	0	845,173	54.00
54.10	03630	ULTRA SOUND	288	3,255	236,795	0	334,577	54.10
54.20	03440	MAMMOGRAPHY	450	1,112	126,399	0	278,075	54.20
56.00	05600	RADIOISOTOPE	49	74,328	82,628	0	328,612	56.00
57.00	05700	CT SCAN	722	5,260	149,732	0	610,654	57.00
58.00	05800	MRI	1,233	0	175,420	0	618,169	58.00
60.00	06000	LABORATORY	2,230	29,090	912,236	0	2,361,529	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	138,854	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	120,524	0	179,509	64.00
65.00	06500	RESPIRATORY THERAPY	418	2,351	333,552	0	487,966	65.00
66.00	06600	PHYSICAL THERAPY	4,426	18,316	673,902	0	1,003,701	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,369	1,280	259,068	0	372,032	67.00
68.00	06800	SPEECH PATHOLOGY	2,051	4,968	257,549	0	469,168	68.00
69.00	06900	ELECTROCARDIOLOGY	232	9,956	223,567	0	332,878	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,760	236,093	0	425,128	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,202	6,008	83,428	0	861,500	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,481,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,018	5,621	532,872	0	2,792,995	73.00
76.00	03950	DIABETES SERVICES	103	0	63,207	0	87,926	76.00
76.97	07697	CARDIAC REHABILITATION	1,364	8,019	92,385	0	136,184	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,247	26,370	1,565,298	0	2,435,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	128,370	1,830,729	16,406,994	-8,868,997	32,149,191	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,335	0	21,867	0	98,758	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,646	0	341,566	0	862,050	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	2,083	0	15,953	0	443,428	192.02
192.03	19203	PULMONARY FUNCTION	0	0	9,256	0	12,990	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,720,279	1,919,827	6,047,213		8,868,997	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.858017	1.048668	0.360047		0.264222	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		1,692,589	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.050425	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	116,692					6.00
7.00	00700	OPERATION OF PLANT	10,212	106,480				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	699	699	241,334			8.00
9.00	00900	HOUSEKEEPING	2,993	2,993	0	102,788		9.00
10.00	01000	DIETARY	809	809	12	809	18,635	10.00
11.00	01100	CAFETERIA	3,227	3,227	32	3,227	0	11.00
13.00	01300	NURSING ADMINISTRATION	291	291	0	291	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,781	1,781	0	1,781	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,459	15,459	76,663	15,459	14,850	30.00
31.00	03100	INTENSIVE CARE UNIT	2,779	2,779	12,133	2,779	3,017	31.00
43.00	04300	NURSERY	355	355	1,214	355	80	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,099	19,099	60,659	19,099	688	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,522	4,522	25,821	4,522	0	54.00
54.10	03630	ULTRA SOUND	288	288	0	288	0	54.10
54.20	03440	MAMMOGRAPHY	450	450	0	450	0	54.20
56.00	05600	RADIOISOTOPE	49	49	0	49	0	56.00
57.00	05700	CT SCAN	722	722	0	722	0	57.00
58.00	05800	MRI	1,233	1,233	0	1,233	0	58.00
60.00	06000	LABORATORY	2,230	2,230	0	2,230	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	418	418	0	418	0	65.00
66.00	06600	PHYSICAL THERAPY	4,426	4,426	4,473	4,426	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,369	1,369	0	1,369	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,051	2,051	0	2,051	0	68.00
69.00	06900	ELECTROCARDIOLOGY	232	232	0	232	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,202	2,202	0	2,202	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,018	1,018	0	1,018	0	73.00
76.00	03950	DIABETES SERVICES	103	103	0	103	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,364	1,364	0	1,364	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,247	6,247	59,374	6,247	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,628	76,416	240,381	72,724	18,635	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,335	5,335	0	5,335	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	22,646	22,646	953	22,646	0	192.00
192.01	19201	CARDIAC PHASE III	0	0	0	0	0	192.01
192.02	19202	FUND DEVELOPMENT	2,083	2,083	0	2,083	0	192.02
192.03	19203	PULMONARY FUNCTION	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	812,556	2,460,825	240,312	1,058,352	276,040	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.963254	23.110678	0.995765	10.296455	14.812986	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	47,011	303,848	18,614	95,978	24,122	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.402864	2.853569	0.077130	0.933747	1.294446	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/23/2018 10:01 am

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	MEDICAL RECORDS & LIBRARY (TOTAL REVENUE)		
			11.00	13.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA	20,800				11.00
13.00	01300	NURSING ADMINISTRATION	1,000	10,500			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	700	0	198,222,022		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,009	4,009	11,479,367		30.00
31.00	03100	INTENSIVE CARE UNIT	1,000	1,000	3,585,314		31.00
43.00	04300	NURSERY	91	91	550,850		43.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,800	2,800	22,466,320		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	100	0	3,189,036		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800	0	6,728,343		54.00
54.10	03630	ULTRA SOUND	300	0	4,513,311		54.10
54.20	03440	MAMMOGRAPHY	200	0	2,639,127		54.20
56.00	05600	RADIOISOTOPE	100	0	3,208,936		56.00
57.00	05700	CT SCAN	200	0	21,547,818		57.00
58.00	05800	MRI	300	0	9,039,449		58.00
60.00	06000	LABORATORY	1,900	0	35,879,980		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	604,304		63.00
64.00	06400	INTRAVENOUS THERAPY	200	0	776,667		64.00
65.00	06500	RESPIRATORY THERAPY	600	0	2,669,315		65.00
66.00	06600	PHYSICAL THERAPY	1,059	0	3,219,612		66.00
67.00	06700	OCCUPATIONAL THERAPY	361	0	2,342,673		67.00
68.00	06800	SPEECH PATHOLOGY	380	0	853,400		68.00
69.00	06900	ELECTROCARDIOLOGY	400	0	6,080,454		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	400	0	2,805,783		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,576,273		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,128,911		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	500	0	19,377,636		73.00
76.00	03950	DIABETES SERVICES	100	100	140,677		76.00
76.97	07697	CARDIAC REHABILITATION	200	0	543,095		76.97
		OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	2,500	2,500	16,275,371		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,200	10,500	198,222,022		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	600	0	0		192.00
192.01	19201	CARDIAC PHASE III	0	0	0		192.01
192.02	19202	FUND DEVELOPMENT	0	0	0		192.02
192.03	19203	PULMONARY FUNCTION	0	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0	0		193.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	686,773	1,484,068	762,051		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.017933	141.339810	0.003844		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,757	96,611	55,990		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3.690240	9.201048	0.000282		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 10:01 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,142,731		7,142,731	0	7,142,731	30.00
31.00	03100	INTENSIVE CARE UNIT	2,052,877		2,052,877	0	2,052,877	31.00
43.00	04300	NURSERY	163,088		163,088	0	163,088	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,664,024		5,664,024	0	5,664,024	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	848,940		848,940	53,825	902,765	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,329,031		1,329,031	0	1,329,031	54.00
54.10	03630	ULTRA SOUND	461,860		461,860	0	461,860	54.10
54.20	03440	MAMMOGRAPHY	386,464		386,464	0	386,464	54.20
56.00	05600	RADIOISOTOPE	433,054		433,054	0	433,054	56.00
57.00	05700	CT SCAN	890,583		890,583	0	890,583	57.00
58.00	05800	MRI	875,933		875,933	0	875,933	58.00
60.00	06000	LABORATORY	3,276,263		3,276,263	0	3,276,263	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	177,865		177,865	0	177,865	63.00
64.00	06400	INTRAVENOUS THERAPY	236,529		236,529	0	236,529	64.00
65.00	06500	RESPIRATORY THERAPY	663,844	0	663,844	0	663,844	65.00
66.00	06600	PHYSICAL THERAPY	1,499,376	0	1,499,376	0	1,499,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	546,523	0	546,523	0	546,523	67.00
68.00	06800	SPEECH PATHOLOGY	691,760	0	691,760	0	691,760	68.00
69.00	06900	ELECTROCARDIOLOGY	466,778		466,778	0	466,778	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	561,448		561,448	11	561,459	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,210,990		1,210,990	0	1,210,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,907,631		1,907,631	0	1,907,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,663,061		3,663,061	0	3,663,061	73.00
76.00	03950	DIABETES SERVICES	133,293		133,293	0	133,293	76.00
76.97	07697	CARDIAC REHABILITATION	235,924		235,924	1,390	237,314	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,889,400		3,889,400	14,020	3,903,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,648,028		1,648,028		1,648,028	92.00
200.00		Subtotal (see instructions)	41,057,298	0	41,057,298	69,246	41,126,544	200.00
201.00		Less Observation Beds	1,648,028		1,648,028		1,648,028	201.00
202.00		Total (see instructions)	39,409,270	0	39,409,270	69,246	39,478,516	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 10:01 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,281,008		8,281,008			30.00
31.00	03100	INTENSIVE CARE UNIT	3,483,149		3,483,149			31.00
43.00	04300	NURSERY	550,850		550,850			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,943,374	16,522,946	22,466,320	0.252112	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,033,820	2,155,216	3,189,036	0.266206	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,534	5,852,809	6,728,343	0.197527	0.000000	54.00
54.10	03630	ULTRA SOUND	295,693	4,217,618	4,513,311	0.102333	0.000000	54.10
54.20	03440	MAMMOGRAPHY	646	2,638,481	2,639,127	0.146436	0.000000	54.20
56.00	05600	RADIOISOTOPE	194,114	3,014,822	3,208,936	0.134953	0.000000	56.00
57.00	05700	CT SCAN	2,623,818	18,924,000	21,547,818	0.041331	0.000000	57.00
58.00	05800	MRI	592,974	8,446,475	9,039,449	0.096901	0.000000	58.00
60.00	06000	LABORATORY	7,395,402	28,484,578	35,879,980	0.091312	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	279,303	325,001	604,304	0.294330	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,499	773,168	776,667	0.304544	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,543,054	1,126,261	2,669,315	0.248695	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	401,857	2,817,755	3,219,612	0.465701	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,042	1,916,631	2,342,673	0.233290	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	120,388	733,012	853,400	0.810593	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,148,990	4,931,464	6,080,454	0.076767	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,738	2,802,045	2,805,783	0.200104	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,161,979	4,414,294	8,576,273	0.141202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,238,902	2,890,009	9,128,911	0.208966	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,189,471	12,188,165	19,377,636	0.189035	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	140,677	140,677	0.947511	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	543,095	543,095	0.434407	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,422,198	13,853,173	16,275,371	0.238975	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	992,730	2,307,794	3,300,524	0.499323	0.000000	92.00
200.00		Subtotal (see instructions)	56,202,533	142,019,489	198,222,022			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,202,533	142,019,489	198,222,022			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 10:01 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	0.252112		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.283084		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197527		54.00
54.10	03630	ULTRA SOUND	0.102333		54.10
54.20	03440	MAMMOGRAPHY	0.146436		54.20
56.00	05600	RADIOISOTOPE	0.134953		56.00
57.00	05700	CT SCAN	0.041331		57.00
58.00	05800	MRI	0.096901		58.00
60.00	06000	LABORATORY	0.091312		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.294330		63.00
64.00	06400	INTRAVENOUS THERAPY	0.304544		64.00
65.00	06500	RESPIRATORY THERAPY	0.248695		65.00
66.00	06600	PHYSICAL THERAPY	0.465701		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233290		67.00
68.00	06800	SPEECH PATHOLOGY	0.810593		68.00
69.00	06900	ELECTROCARDIOLOGY	0.076767		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.200108		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.141202		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208966		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189035		73.00
76.00	03950	DIABETES SERVICES	0.947511		76.00
76.97	07697	CARDIAC REHABILITATION	0.436966		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.239836		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.499323		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 10:01 am

Title XIX | Hospital | Cost

		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	7,142,731		7,142,731	0	7,142,731	30.00
31.00	03100	INTENSIVE CARE UNIT	2,052,877		2,052,877	0	2,052,877	31.00
43.00	04300	NURSERY	163,088		163,088	0	163,088	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,664,024		5,664,024	0	5,664,024	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	848,940		848,940	53,825	902,765	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,329,031		1,329,031	0	1,329,031	54.00
54.10	03630	ULTRA SOUND	461,860		461,860	0	461,860	54.10
54.20	03440	MAMMOGRAPHY	386,464		386,464	0	386,464	54.20
56.00	05600	RADIOISOTOPE	433,054		433,054	0	433,054	56.00
57.00	05700	CT SCAN	890,583		890,583	0	890,583	57.00
58.00	05800	MRI	875,933		875,933	0	875,933	58.00
60.00	06000	LABORATORY	3,276,263		3,276,263	0	3,276,263	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	177,865		177,865	0	177,865	63.00
64.00	06400	INTRAVENOUS THERAPY	236,529		236,529	0	236,529	64.00
65.00	06500	RESPIRATORY THERAPY	663,844	0	663,844	0	663,844	65.00
66.00	06600	PHYSICAL THERAPY	1,499,376	0	1,499,376	0	1,499,376	66.00
67.00	06700	OCCUPATIONAL THERAPY	546,523	0	546,523	0	546,523	67.00
68.00	06800	SPEECH PATHOLOGY	691,760	0	691,760	0	691,760	68.00
69.00	06900	ELECTROCARDIOLOGY	466,778		466,778	0	466,778	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	561,448		561,448	11	561,459	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,210,990		1,210,990	0	1,210,990	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,907,631		1,907,631	0	1,907,631	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,663,061		3,663,061	0	3,663,061	73.00
76.00	03950	DIABETES SERVICES	133,293		133,293	0	133,293	76.00
76.97	07697	CARDIAC REHABILITATION	235,924		235,924	1,390	237,314	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	3,889,400		3,889,400	14,020	3,903,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,648,028		1,648,028		1,648,028	92.00
200.00		Subtotal (see instructions)	41,057,298	0	41,057,298	69,246	41,126,544	200.00
201.00		Less Observation Beds	1,648,028		1,648,028		1,648,028	201.00
202.00		Total (see instructions)	39,409,270	0	39,409,270	69,246	39,478,516	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 10:01 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,281,008		8,281,008			30.00
31.00	03100	INTENSIVE CARE UNIT	3,483,149		3,483,149			31.00
43.00	04300	NURSERY	550,850		550,850			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,943,374	16,522,946	22,466,320	0.252112	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	1,033,820	2,155,216	3,189,036	0.266206	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,534	5,852,809	6,728,343	0.197527	0.000000	54.00
54.10	03630	ULTRA SOUND	295,693	4,217,618	4,513,311	0.102333	0.000000	54.10
54.20	03440	MAMMOGRAPHY	646	2,638,481	2,639,127	0.146436	0.000000	54.20
56.00	05600	RADIOISOTOPE	194,114	3,014,822	3,208,936	0.134953	0.000000	56.00
57.00	05700	CT SCAN	2,623,818	18,924,000	21,547,818	0.041331	0.000000	57.00
58.00	05800	MRI	592,974	8,446,475	9,039,449	0.096901	0.000000	58.00
60.00	06000	LABORATORY	7,395,402	28,484,578	35,879,980	0.091312	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	279,303	325,001	604,304	0.294330	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	3,499	773,168	776,667	0.304544	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,543,054	1,126,261	2,669,315	0.248695	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	401,857	2,817,755	3,219,612	0.465701	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	426,042	1,916,631	2,342,673	0.233290	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	120,388	733,012	853,400	0.810593	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,148,990	4,931,464	6,080,454	0.076767	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,738	2,802,045	2,805,783	0.200104	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,161,979	4,414,294	8,576,273	0.141202	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,238,902	2,890,009	9,128,911	0.208966	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,189,471	12,188,165	19,377,636	0.189035	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	140,677	140,677	0.947511	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	543,095	543,095	0.434407	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	2,422,198	13,853,173	16,275,371	0.238975	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	992,730	2,307,794	3,300,524	0.499323	0.000000	92.00
200.00		Subtotal (see instructions)	56,202,533	142,019,489	198,222,022			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	56,202,533	142,019,489	198,222,022			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/23/2018 10:01 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.10	03630	ULTRA SOUND	0.000000		54.10
54.20	03440	MAMMOGRAPHY	0.000000		54.20
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	DIABETES SERVICES	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
		OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/23/2018 10:01 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	625,852	0	625,852	5,630	111.16	30.00
31.00	INTENSIVE CARE UNIT	173,738		173,738	1,079	161.02	31.00
43.00	NURSERY	16,749		16,749	396	42.30	43.00
200.00	Total (lines 30 through 199)	816,339		816,339	7,105		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	2,708	301,021		30.00
31.00	INTENSIVE CARE UNIT	512	82,442		31.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30 through 199)	3,220	383,463		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/23/2018 10:01 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	749,912	22,466,320	0.033379	2,433,101	81,214	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	62,612	3,189,036	0.019634	337,780	6,632	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	171,157	6,728,343	0.025438	546,849	13,911	54.00
54.10	03630	ULTRA SOUND	26,998	4,513,311	0.005982	167,441	1,002	54.10
54.20	03440	MAMMOGRAPHY	93,280	2,639,127	0.035345	0	0	54.20
56.00	05600	RADIOISOTOPE	96,527	3,208,936	0.030081	115,394	3,471	56.00
57.00	05700	CT SCAN	146,986	21,547,818	0.006821	1,380,822	9,419	57.00
58.00	05800	MRI	310,599	9,039,449	0.034360	394,218	13,545	58.00
60.00	06000	LABORATORY	295,751	35,879,980	0.008243	4,106,932	33,853	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,172	604,304	0.011868	185,449	2,201	63.00
64.00	06400	INTRAVENOUS THERAPY	10,009	776,667	0.012887	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	41,506	2,669,315	0.015549	1,044,993	16,249	65.00
66.00	06600	PHYSICAL THERAPY	141,584	3,219,612	0.043975	241,462	10,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,697	2,342,673	0.018226	248,971	4,538	67.00
68.00	06800	SPEECH PATHOLOGY	61,375	853,400	0.071918	87,881	6,320	68.00
69.00	06900	ELECTROCARDIOLOGY	33,908	6,080,454	0.005577	730,463	4,074	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	101,173	2,805,783	0.036059	3,738	135	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	85,296	8,576,273	0.009946	2,388,208	23,753	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,262	9,128,911	0.008463	3,248,132	27,489	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	220,587	19,377,636	0.011384	3,882,272	44,196	73.00
76.00	03950	DIABETES SERVICES	7,312	140,677	0.051977	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	36,693	543,095	0.067563	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	285,893	16,275,371	0.017566	1,406,993	24,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	144,402	3,300,524	0.043751	593,063	25,947	92.00
200.00		Total (lines 50 through 199)	3,250,691	185,907,015		23,544,162	353,282	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/23/2018 10:01 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	5,630	0.00	2,708	30.00
31.00	03100	INTENSIVE CARE UNIT		0	1,079	0.00	512	31.00
43.00	04300	NURSERY		0	396	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	7,105		3,220	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/23/2018 10:01 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
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.10	03630	ULTRA SOUND	0	0	0	0	0	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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 PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETES SERVICES	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/23/2018 10:01 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	22,466,320	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	3,189,036	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,728,343	0.000000	54.00
54.10	03630	ULTRA SOUND	0	0	0	4,513,311	0.000000	54.10
54.20	03440	MAMMOGRAPHY	0	0	0	2,639,127	0.000000	54.20
56.00	05600	RADIOISOTOPE	0	0	0	3,208,936	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	21,547,818	0.000000	57.00
58.00	05800	MRI	0	0	0	9,039,449	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	35,879,980	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	604,304	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	776,667	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,669,315	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,219,612	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,342,673	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	853,400	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	6,080,454	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,805,783	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	8,576,273	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,128,911	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,377,636	0.000000	73.00
76.00	03950	DIABETES SERVICES	0	0	0	140,677	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	543,095	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0	0	0	16,275,371	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	3,300,524	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	185,907,015		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/23/2018 10:01 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	2,433,101	0	4,052,094	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	337,780	0	564,876	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	546,849	0	1,639,076	0	54.00
54.10	03630	ULTRA SOUND	0.000000	167,441	0	950,541	0	54.10
54.20	03440	MAMMOGRAPHY	0.000000	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0.000000	115,394	0	1,223,607	0	56.00
57.00	05700	CT SCAN	0.000000	1,380,822	0	10,736,474	0	57.00
58.00	05800	MRI	0.000000	394,218	0	2,220,633	0	58.00
60.00	06000	LABORATORY	0.000000	4,106,932	0	3,524,233	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	185,449	0	201,843	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	268,633	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,044,993	0	486,049	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	241,462	0	24,832	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	248,971	0	21,962	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	87,881	0	46,256	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	730,463	0	1,914,889	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,738	0	667,458	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,388,208	0	1,049,294	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	3,248,132	0	775,200	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	3,882,272	0	659,410	0	73.00
76.00	03950	DIABETES SERVICES	0.000000	0	0	698	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	228,021	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000	1,406,993	0	3,468,691	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	593,063	0	824,004	0	92.00
200.00		Total (lines 50 through 199)		23,544,162	0	35,548,774	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/23/2018 10:01 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	0.252112	4,052,094	0	0	1,021,582	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.266206	564,876	0	0	150,373	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197527	1,639,076	0	0	323,762	54.00
54.10	03630	ULTRA SOUND	0.102333	950,541	0	0	97,272	54.10
54.20	03440	MAMMOGRAPHY	0.146436	0	0	0	0	54.20
56.00	05600	RADIOISOTOPE	0.134953	1,223,607	0	0	165,129	56.00
57.00	05700	CT SCAN	0.041331	10,736,474	0	0	443,749	57.00
58.00	05800	MRI	0.096901	2,220,633	0	0	215,182	58.00
60.00	06000	LABORATORY	0.091312	3,524,233	0	0	321,805	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.294330	201,843	0	0	59,408	63.00
64.00	06400	INTRAVENOUS THERAPY	0.304544	268,633	0	0	81,811	64.00
65.00	06500	RESPIRATORY THERAPY	0.248695	486,049	0	0	120,878	65.00
66.00	06600	PHYSICAL THERAPY	0.465701	24,832	0	0	11,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233290	21,962	0	0	5,124	67.00
68.00	06800	SPEECH PATHOLOGY	0.810593	46,256	0	0	37,495	68.00
69.00	06900	ELECTROCARDIOLOGY	0.076767	1,914,889	0	0	147,000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.200104	667,458	0	0	133,561	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.141202	1,049,294	0	0	148,162	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208966	775,200	0	0	161,990	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189035	659,410	0	87,879	124,652	73.00
76.00	03950	DIABETES SERVICES	0.947511	698	0	0	661	76.00
76.97	07697	CARDIAC REHABILITATION	0.434407	228,021	0	0	99,054	76.97
		OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.238975	3,468,691	0	0	828,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.499323	824,004	0	0	411,444	92.00
200.00		Subtotal (see instructions)		35,548,774	0	87,879	5,110,588	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		35,548,774	0	87,879	5,110,588	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/23/2018 10:01 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
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.10	03630	ULTRA SOUND	0	0		54.10
54.20	03440	MAMMOGRAPHY	0	0		54.20
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16,612		73.00
76.00	03950	DIABETES SERVICES	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	16,612		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	16,612		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/23/2018 10:01 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)	5,721	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,630	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)	4,331	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	91	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)	2,708	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)	20	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	7,142,731	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7,142,731	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)	7,142,731	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,268.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,435,613	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)	3,435,613	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 10:01 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	2,052,877	1,079	1,902.57	512	974,116	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)	4,316,532	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,726,261	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)	383,463	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	353,282	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	736,745	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,989,516	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,299	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,268.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,648,028	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/23/2018 10:01 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	625,852	7,142,731	0.087621	1,648,028	144,402	90.00
91.00	Nursing School cost	0	7,142,731	0.000000	1,648,028	0	91.00
92.00	Allied health cost	0	7,142,731	0.000000	1,648,028	0	92.00
93.00	All other Medical Education	0	7,142,731	0.000000	1,648,028	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/23/2018 10:01 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		4,121,461		30.00
31.00	03100	INTENSIVE CARE UNIT		1,614,336		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.252112	2,433,101	613,414	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.283084	337,780	95,620	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197527	546,849	108,017	54.00
54.10	03630	ULTRA SOUND	0.102333	167,441	17,135	54.10
54.20	03440	MAMMOGRAPHY	0.146436	0	0	54.20
56.00	05600	RADIOISOTOPE	0.134953	115,394	15,573	56.00
57.00	05700	CT SCAN	0.041331	1,380,822	57,071	57.00
58.00	05800	MRI	0.096901	394,218	38,200	58.00
60.00	06000	LABORATORY	0.091312	4,106,932	375,012	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.294330	185,449	54,583	63.00
64.00	06400	INTRAVENOUS THERAPY	0.304544	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.248695	1,044,993	259,885	65.00
66.00	06600	PHYSICAL THERAPY	0.465701	241,462	112,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233290	248,971	58,082	67.00
68.00	06800	SPEECH PATHOLOGY	0.810593	87,881	71,236	68.00
69.00	06900	ELECTROCARDIOLOGY	0.076767	730,463	56,075	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.200108	3,738	748	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.141202	2,388,208	337,220	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208966	3,248,132	678,749	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189035	3,882,272	733,885	73.00
76.00	03950	DIABETES SERVICES	0.947511	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.436966	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.239836	1,406,993	337,448	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.499323	593,063	296,130	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		23,544,162	4,316,532	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)		23,544,162		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/23/2018 10:01 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	0.252112	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.266206	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.197527	365	72	54.00
54.10	03630	ULTRA SOUND	0.102333	0	0	54.10
54.20	03440	MAMMOGRAPHY	0.146436	0	0	54.20
56.00	05600	RADIOISOTOPE	0.134953	0	0	56.00
57.00	05700	CT SCAN	0.041331	0	0	57.00
58.00	05800	MRI	0.096901	0	0	58.00
60.00	06000	LABORATORY	0.091312	7,442	680	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.294330	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.304544	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.248695	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.465701	1,789	833	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.233290	2,846	664	67.00
68.00	06800	SPEECH PATHOLOGY	0.810593	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.076767	273	21	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.200104	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.141202	4,149	586	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.208966	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.189035	11,324	2,141	73.00
76.00	03950	DIABETES SERVICES	0.947511	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.434407	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0.238975	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.499323	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		28,188	4,997	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)		28,188		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/23/2018 10:01 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)	6,579,274	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)	3,087	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	1,699,549	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	38.19	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)	2.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)	16.29	31.00
32.00	Sum of lines 30 and 31	18.92	32.00
33.00	Allowable disproportionate share percentage (see instructions)	5.05	33.00
34.00	Disproportionate share adjustment (see instructions)	83,063	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A | Date/Time Prepared: 2/23/2018 10:01 am

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000029178	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	174,557	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	174,557	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	174,557		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)	6,839,981		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	8,686,715		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		8,686,715	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		533,554	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)		9,220,269	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		9,220,269	61.00
62.00	Deductibles billed to program beneficiaries		866,628	62.00
63.00	Coinsurance billed to program beneficiaries		2,268	63.00
64.00	Allowable bad debts (see instructions)		149,896	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		97,432	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		24,503	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		8,448,805	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		184,397	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/23/2018 10:01 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	1,346,814	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)		9,980,016	71.00
71.01	Sequestration adjustment (see instructions)		199,600	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		9,765,543	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)		14,873	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		334,160	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/23/2018 10:01 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	16,612	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,110,588	2.00
3.00	OPPS payments	5,071,072	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	16,612	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	87,879	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)	87,879	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)	87,879	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	71,267	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)	16,612	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)	5,071,072	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)	1,041,469	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)	4,046,215	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)	4,046,215	30.00
31.00	Primary payer payments	389	31.00
32.00	Subtotal (line 30 minus line 31)	4,045,826	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)	197,585	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	128,430	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	40,797	36.00
37.00	Subtotal (see instructions)	4,174,256	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	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)	4,174,256	40.00
40.01	Sequestration adjustment (see instructions)	83,485	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	4,103,951	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-13,180	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2018 10:01 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		9,765,543		4,103,951	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)		9,765,543		4,103,951	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		14,873		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		13,180	6.02
7.00	Total Medicare program liability (see instructions)		9,780,416		4,090,771	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: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2018 10:01 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		4,408		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)		4,408		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)		4,408		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: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/23/2018 10:01 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: 14-0161 | Component CCN: 14-U161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E-2 | Date/Time Prepared: 2/23/2018 10:01 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)	4,498	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	20	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)	4,498	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	4,498	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)	4,498	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	4,498	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)	4,498	0	19.00
19.01	Sequestration adjustment (see instructions)	90	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
20.00	Interim payments	4,408	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: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/23/2018 10:01 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	699,580	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	51,733,957	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-39,134,896	0	0	0	6.00
7.00	Inventory	865,565	0	0	0	7.00
8.00	Prepaid expenses	14,666	0	0	0	8.00
9.00	Other current assets	573,806	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)	14,752,678	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	600,013	0	0	0	12.00
13.00	Land improvements	2,380,415	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,715,353	0	0	0	15.00
16.00	Accumulated depreciation	-23,610,568	0	0	0	16.00
17.00	Leasehold improvements	7,095	0	0	0	17.00
18.00	Accumulated depreciation	-2,278,932	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	23,596,898	0	0	0	23.00
24.00	Accumulated depreciation	-16,720,180	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	589,220	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	23,279,314	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	37,189,883	397,551	854,108	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	37,189,883	397,551	854,108	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	75,221,875	397,551	854,108	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,053,754	0	0	0	37.00
38.00	Salaries, wages, and fees payable	8,217	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	30,689	0	0	0	43.00
44.00	Other current liabilities	4,283,280	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,375,940	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	71,800	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	71,800	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	5,447,740	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	69,774,135				52.00
53.00	Specific purpose fund		397,551			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			854,108		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)	69,774,135	397,551	854,108	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	75,221,875	397,551	854,108	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/23/2018 10:01 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		61,787,966		457,511		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		18,617,559				2.00
3.00	Total (sum of line 1 and line 2)		80,405,525		457,511		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	INCREASE IN RESTRICTED ASSETS	0		55,255		0	5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED	0		97,484		0	6.00
7.00	EQUITY TRANSFER	-272,185		-4,097		0	7.00
8.00	EQUITY TRANSFER	0		-98		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		-272,185		148,544		10.00
11.00	Subtotal (line 3 plus line 10)		80,133,340		606,055		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	EQUITY TRANSFER	10,359,205		0		0	13.00
14.00	DECREASE IN RESTRICTED ASSETS	0		208,504		1,104	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)		10,359,205		208,504		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		69,774,135		397,551		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	855,212		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)	855,212		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	INCREASE IN RESTRICTED ASSETS		0			5.00
6.00	CONTRIBUTIONS TEMP RESTRICTED		0			6.00
7.00	EQUITY TRANSFER		0			7.00
8.00	EQUITY TRANSFER		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)	855,212		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00	EQUITY TRANSFER		0			13.00
14.00	DECREASE IN RESTRICTED ASSETS		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)	1,104		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	854,108		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0161 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2018 10:01 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	8,910,953		8,910,953	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)	8,910,953		8,910,953	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	3,462,635		3,462,635	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)	3,462,635		3,462,635	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	12,373,588		12,373,588	17.00
18.00	Ancillary services	43,884,027	141,280,635	185,164,662	18.00
19.00	Outpatient services	0	683,772	683,772	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES - OTHER NRCC	1,277,313	11,179,011	12,456,324	27.00
27.01	OTHER NRCC	0	245,671	245,671	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	57,534,928	153,389,089	210,924,017	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,675,312		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)		47,675,312		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet G-3 Date/Time Prepared: 2/23/2018 10:01 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	210,924,017	1.00
2.00	Less contractual allowances and discounts on patients' accounts	147,463,612	2.00
3.00	Net patient revenues (line 1 minus line 2)	63,460,405	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	47,675,312	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,785,093	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	441,639	6.00
7.00	Income from investments	1,966,248	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	133,155	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	-51,297	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	11,815	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME - PHYS OFFICE RENTAL	277,906	24.00
24.01	RENTAL OF PHYSICIAN OFFICES	65,854	24.01
25.00	Total other income (sum of lines 6-24)	2,845,320	25.00
26.00	Total (line 5 plus line 25)	18,630,413	26.00
27.00	FEDERAL AND STATE INCOME TAXES	12,854	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	12,854	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	18,617,559	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0161	Period: From 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/23/2018 10:01 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	532,615	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	939	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)	14.94	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)	533,554	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