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: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/29/2018 4:30 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/29/2018 Time: 4:30 pm
2. [ ] Manually submitted cost report
3. [1] 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 PRESENCE SAINT JOSEPH HOSP-CHICAGO (14-0224) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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) FLAVIO MARIN
Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

05/29/2018 04:30:15 PM
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	406,593	-86,257	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	65,117	22		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	10,788	0		0	7.00
200.00	Total	0	482,498	-86,235	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 2900 NORTH LAKE SHORE DRIVE	PO Box:			1.00
2.00	City: CHICAGO	State: IL	Zip Code: 60657	County: COOK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PRESENCE SAINT JOSEPH HOSP-CHICAGO	140224	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	REHAB UNIT	14T224	16974	5	07/01/1985	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	SKILLED CARE	145568	16974		01/28/1987	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2017	12/31/2017	20.00
21.00	Type of Control (see instructions)	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.	2,657	4,617	0	0	3,671	361	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.	341	116	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/29/2018 4:29 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

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

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

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

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	8.12	29.85	0.213853	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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	FAMILY MEDICINE	1350	0.57	16.24	0.033908	65.00
65.01		INTERNAL MEDICINE	1400	2.88	62.28	0.044199	65.01

		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)	9.23	33.94	0.213806	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)	FAMILY MEDICINE	1350	0.97	17.01	0.053949	67.00
67.01		INTERNAL MEDICINE	1400	0.50	74.45	0.006671	67.01

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

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		1.00	2.00	3.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	6,634,752	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y	5.06	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	14H082	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: PRESENCE HEALTH NETWORK	Contractor's Name: NGS	Contractor's Number: 00131	141.00
142.00	Street: 200 S. WACKER DRIVE	PO Box:		142.00
143.00	City: CHICAGO	State: IL	Zip Code: 60606	143.00

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

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

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

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

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

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

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

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

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/29/2018 4:29 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	05/11/2018	Y	05/11/2018	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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 4:29 pm

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

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK	GILLILAND	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRSENCE HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3718	PATRICK.GILLILAND@PRESENCEHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/29/2018 4:29 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT		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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	258	94,170	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)		258	94,170	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	19	6,935	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)		277	101,105	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	10	3,650		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	26	9,490		0	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)		313				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)		1	365			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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	14,842	918	48,547			1.00
2.00	HMO and other (see instructions)	4,623	8,449				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	170	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	14,842	918	48,547			7.00
8.00	INTENSIVE CARE UNIT	1,858	100	3,334			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,424	4,881			13.00
14.00	Total (see instructions)	16,700	2,442	56,762	121.28	1,580.54	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	769	120	1,775	0.00	20.72	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	5,588	0	7,462	0.00	47.52	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	294			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)				121.28	1,648.78	27.00
28.00	Observation Bed Days		788	4,598			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	415	771			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			15			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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,164	391	10,843	1.00
2.00	HMO and other (see instructions)			905	2,713		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	3,164	391	10,843	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	70	7	181	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2018 4:29 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	75,145,752	401,395	75,547,147	2,333,167.82	32.38	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		1,304,882	0	1,304,882	10,318.00	126.47	4.00
4.01	Physicians - Part A - Teaching		614,011	0	614,011	9,591.00	64.02	4.01
5.00	Physician and Non Physician-Part B		38,000	0	38,000	260.00	146.15	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	7,859,270	7,859,270	290,000.00	27.10	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	1,974,912	0	1,974,912	58,351.18	33.85	9.00
10.00	Excluded area salaries (see instructions)		4,786,634	50,270	4,836,904	126,561.45	38.22	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		4,263,817	0	4,263,817	105,229.65	40.52	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		0	0	0	0.00	0.00	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		13,623,714	0	13,623,714	336,262.00	40.52	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		16,054,389	0	16,054,389			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,683,701	0	1,683,701			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		162,194	0	162,194			22.00
22.01	Physician Part A - Teaching		106,685	0	106,685			22.01
23.00	Physician Part B		4,464	0	4,464			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		1,606,957	0	1,606,957			25.00
25.50	Home office wage-related (core)		3,706,842	0	3,706,842			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	-322,346	401,395	79,049	7,155.20	11.05	26.00
27.00	Administrative & General	5.00	5,918,246	0	5,918,246	307,216.00	19.26	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/29/2018 4:29 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		4,958,922	0	4,958,922	26,747.00	185.40	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	113,169	0	113,169	9,776.00	11.58	31.00
32.00	Housekeeping	9.00	1,556,405	0	1,556,405	170,331.20	9.14	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,711,257	-846,889	864,368	68,480.13	12.62	34.00
35.00	Dietary under contract (see instructions)		887,384	0	887,384	14,560.00	60.95	35.00
36.00	Cafeteria	11.00	0	846,889	846,889	79,652.91	10.63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,281,296	0	1,281,296	29,411.20	43.56	38.00
39.00	Central Services and Supply	14.00	224,085	0	224,085	13,644.80	16.42	39.00
40.00	Pharmacy	15.00	2,367,291	-50,270	2,317,021	79,081.60	29.30	40.00
41.00	Medical Records & Medical Records Library	16.00	71,360	0	71,360	2,953.60	24.16	41.00
42.00	Social Service	17.00	1,414,789	0	1,414,789	37,169.60	38.06	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/29/2018 4:29 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		80,340,047	-7,457,875	72,882,172	2,074,623.82	35.13	1.00
2.00	Excluded area salaries (see instructions)		6,761,546	50,270	6,811,816	184,912.63	36.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)		73,578,501	-7,508,145	66,070,356	1,889,711.19	34.96	3.00
4.00	Subtotal other wages & related costs (see inst.)		17,887,531	0	17,887,531	441,491.65	40.52	4.00
5.00	Subtotal wage-related costs (see inst.)		19,923,425	0	19,923,425	0.00	30.15	5.00
6.00	Total (sum of lines 3 thru 5)		111,389,457	-7,508,145	103,881,312	2,331,202.84	44.56	6.00
7.00	Total overhead cost (see instructions)		20,181,858	351,125	20,532,983	846,179.24	24.27	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/29/2018 4:29 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,938,161	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)	2,897,361	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	6,644,438	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	192,766	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	42,133	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)	216,686	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	914,647	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	5,530,676	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	97,227	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	144,296	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	19,618,391	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	4,269,866	20,900,236	1.00
2.00	Hospital	4,263,817	16,054,389	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	738	246,038	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	1,053,325	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	5,311	3,546,484	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-7 | Date/Time Prepared: 5/29/2018 4:29 pm

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

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	145	0	145	12.00
13.00		RUB	1,849	0	1,849	13.00
14.00		RUA	1,451	0	1,451	14.00
15.00		RVC	109	0	109	15.00
16.00		RVB	764	0	764	16.00
17.00		RVA	730	0	730	17.00
18.00		RHC	22	0	22	18.00
19.00		RHB	118	0	118	19.00
20.00		RHA	80	0	80	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	9	0	9	22.00
23.00		RMA	27	0	27	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	9	0	9	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	7	0	7	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	7	0	7	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	4	0	4	40.00
41.00		LC2	2	0	2	41.00
42.00		LC1	16	0	16	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	3	0	3	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	1	0	1	47.00
48.00		CD1	3	0	3	48.00
49.00		CC2	3	0	3	49.00
50.00		CC1	39	0	39	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	55	0	55	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	56	0	56	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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-7 | Date/Time Prepared: 5/29/2018 4:29 pm

		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	14	0	14	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	44	0	44	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	21	0	21	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		5,588	0	5,588	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	16974	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)	8,428,894			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/29/2018 4:29 pm

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.208924	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			19,339,352	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	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			124,114,012	6.00
7.00	Medicaid cost (line 1 times line 6)			25,930,396	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			6,591,044	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)			6,591,044	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	5,801,543	26,831	5,828,374	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,212,082	26,831	1,238,913	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,212,082	26,831	1,238,913	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)			3,224,133	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			500,274	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			769,651	27.01
28.00	Non-Medicare bad debt expense (see instructions)			2,454,482	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			782,177	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,021,090	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,612,134	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,245,011	5,245,011	-5,245,011	0	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	15,421,547	15,421,547	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-322,346	-545,043	-867,389	0	-867,389	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	157,049	157,049	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	5,918,246	76,304,926	82,223,172	-7,029,846	75,193,326	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2,551,119	2,551,119	-39	2,551,080	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	113,169	622,573	735,742	0	735,742	8.00
9.00	00900	HOUSEKEEPING	1,556,405	1,658,301	3,214,706	-14,234	3,200,472	9.00
10.00	01000	DIETARY	1,711,257	2,904,274	4,615,531	-2,397,674	2,217,857	10.00
11.00	01100	CAFETERIA	0	0	0	2,344,473	2,344,473	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,281,296	1,567,628	2,848,924	-428,558	2,420,366	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	224,085	-285,170	-61,085	-112,791	-173,876	14.00
15.00	01500	PHARMACY	2,367,291	6,333,103	8,700,394	-5,474,189	3,226,205	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	71,360	191,060	262,420	-6,419	256,001	16.00
17.00	01700	SOCIAL SERVICE	1,414,789	544,087	1,958,876	0	1,958,876	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	10,382,407	10,382,407	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	11,730,594	5,404,002	17,134,596	-11,442,905	5,691,691	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	155,695	35,196	190,891	66,673	257,564	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,549,437	9,005,716	27,555,153	-815,731	26,739,422	30.00
31.00	03100	INTENSIVE CARE UNIT	2,524,009	1,117,559	3,641,568	-184,134	3,457,434	31.00
41.00	04100	SUBPROVIDER - IRF	723,694	207,850	931,544	-13,347	918,197	41.00
43.00	04300	NURSERY	1,935,844	472,985	2,408,829	245,405	2,654,234	43.00
44.00	04400	SKILLED NURSING FACILITY	1,974,912	696,821	2,671,733	-49,884	2,621,849	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,795,902	18,334,586	24,130,488	-12,934,895	11,195,593	50.00
51.00	05100	RECOVERY ROOM	636,682	165,354	802,036	-31,891	770,145	51.00
53.00	05300	ANESTHESIOLOGY	126,807	857,663	984,470	-435,826	548,644	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,551,599	1,479,494	4,031,093	-205,653	3,825,440	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,350,798	1,883,081	3,233,879	-176,940	3,056,939	55.00
57.00	05700	CT SCAN	416,062	217,405	633,467	-96,757	536,710	57.00
58.00	05800	MRI	322,551	286,643	609,194	-205,580	403,614	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,175,246	2,353,679	3,528,925	-1,400,343	2,128,582	59.00
60.00	06000	LABORATORY	0	7,399,314	7,399,314	-93,850	7,305,464	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	528,337	528,337	11,568	539,905	63.00
65.00	06500	RESPIRATORY THERAPY	952,051	546,582	1,498,633	-129,320	1,369,313	65.00
66.00	06600	PHYSICAL THERAPY	2,363,722	3,388,540	5,752,262	-59,621	5,692,641	66.00
69.00	06900	ELECTROCARDIOLOGY	354,134	629,166	983,300	-48,150	935,150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	53,021	27,360	80,381	-10,359	70,022	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,145,317	7,145,317	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,691,575	7,691,575	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,132,380	7,132,380	73.00
74.00	07400	RENAL DIALYSIS	0	543,521	543,521	348	543,869	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	62,600	13,383	75,983	-2,423	73,560	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	472,870	197,735	670,605	-78,414	592,191	90.00
91.00	09100	EMERGENCY	2,488,615	2,101,809	4,590,424	-704,720	3,885,704	91.00
91.01	09101	PARTIAL HOSPITALIZATION	186,110	46,956	233,066	-252	232,814	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,238,507	155,032,606	226,271,113	768,986	227,040,099	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	3,907,245	2,638,558	6,545,803	-768,986	5,776,817	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	75,145,752	157,671,164	232,816,916	0	232,816,916	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	885,601	885,601		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	808,426	16,229,973		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	476,149	-391,240		4.00
5.01	00540	NONPATIENT TELEPHONES	0	157,049		5.01
5.02	00550	DATA PROCESSING	2,624,387	2,624,387		5.02
5.03	00560	PURCHASING,RECEIVING&STORES	166,134	166,134		5.03
5.04	00570	ADMITTING	0	0		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	4,337,214	4,337,214		5.05
5.06	00591	ADMINISTRATION & GENERAL	-16,939,260	58,254,066		5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	2,551,080		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	735,742		8.00
9.00	00900	HOUSEKEEPING	0	3,200,472		9.00
10.00	01000	DIETARY	0	2,217,857		10.00
11.00	01100	CAFETERIA	-1,136,698	1,207,775		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	2,420,366		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	857,315	683,439		14.00
15.00	01500	PHARMACY	-48,100	3,178,105		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,507,252	1,763,253		16.00
17.00	01700	SOCIAL SERVICE	0	1,958,876		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	10,382,407		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-314,027	5,377,664		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	257,564		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,259,419	25,480,003		30.00
31.00	03100	INTENSIVE CARE UNIT	432,303	3,889,737		31.00
41.00	04100	SUBPROVIDER - IRF	0	918,197		41.00
43.00	04300	NURSERY	-633	2,653,601		43.00
44.00	04400	SKILLED NURSING FACILITY	-27,218	2,594,631		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-1,003,562	10,192,031		50.00
51.00	05100	RECOVERY ROOM	0	770,145		51.00
53.00	05300	ANESTHESIOLOGY	-342,492	206,152		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-297,680	3,527,760		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-991,610	2,065,329		55.00
57.00	05700	CT SCAN	0	536,710		57.00
58.00	05800	MRI	0	403,614		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,128,582		59.00
60.00	06000	LABORATORY	15,527	7,320,991		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	539,905		63.00
65.00	06500	RESPIRATORY THERAPY	0	1,369,313		65.00
66.00	06600	PHYSICAL THERAPY	-2,285,915	3,406,726		66.00
69.00	06900	ELECTROCARDIOLOGY	-361,541	573,609		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-4,671	65,351		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,145,317		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,691,575		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,132,380		73.00
74.00	07400	RENAL DIALYSIS	0	543,869		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	73,560		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	-4,565	587,626		90.00
91.00	09100	EMERGENCY	-490,618	3,395,086		91.00
91.01	09101	PARTIAL HOSPITALIZATION	-26,000	206,814		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-13,423,701	213,616,398		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER	-1,400,620	4,376,197		194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-14,824,321	217,992,595		200.00

RECLASSIFICATIONS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:29 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,132,380	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	TOTALS		0	7,132,380	
	B - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	7,691,575	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
	TOTALS		0	7,691,575	
	C - CHARGABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,145,317	1.00
2.00	RENAL DIALYSIS	74.00	0	348	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00

RECLASSIFICATIONS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:29 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
	TOTALS		0	7,145,665	
	D - NURSEY				
1.00	NURSERY	43.00	225,795	79,980	1.00
	TOTALS		225,795	79,980	
	E - CAFETERIA				
1.00	CAFETERIA	11.00	846,889	1,497,584	1.00
	TOTALS		846,889	1,497,584	
	F - PHYSICIAN DEPR CHAIRMAN				
1.00	ADULTS & PEDIATRICS	30.00	959,678	95,417	1.00
	TOTALS		959,678	95,417	
	G - SALARY EARNED TIME OFF ACCRUAL				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	401,395	0	1.00
	TOTALS		401,395	0	
	H - EQUIP DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,421,547	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
	TOTALS		0	15,421,547	
	I - PHONES				
1.00	NONPATIENT TELEPHONES	5.01	0	157,049	1.00
	TOTALS		0	157,049	
	J - PHARMACY RESIDENCY COSTS				
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	50,270	16,403	1.00
	TOTALS		50,270	16,403	
	L - INTERNS AND RESIDENTS SALARY				
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	7,859,270	2,523,137	1.00
	TOTALS		7,859,270	2,523,137	
	M - BLOOD RECLASS				
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	11,568	1.00
	TOTALS		0	11,568	
500.00	Grand Total: Increases		10,343,297	41,772,305	500.00

RECLASSIFICATIONS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:29 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS						
1.00	ADMINISTRATION & GENERAL	5.06	0	73	0		1.00
2.00	OPERATION OF PLANT	7.00	0	39	0		2.00
3.00	DIETARY	10.00	0	752	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,088	0		4.00
5.00	PHARMACY	15.00	0	5,344,172	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,402	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	329,066	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	51,374	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	1,749	0		9.00
10.00	NURSERY	43.00	0	9,433	0		10.00
11.00	SKILLED NURSING FACILITY	44.00	0	7,199	0		11.00
12.00	OPERATING ROOM	50.00	0	248,622	0		12.00
13.00	RECOVERY ROOM	51.00	0	10,026	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	215,474	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	20,465	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	4,059	0		16.00
17.00	CT SCAN	57.00	0	45,390	0		17.00
18.00	MRI	58.00	0	56,783	0		18.00
19.00	CARDIAC CATHETERIZATION	59.00	0	61,742	0		19.00
20.00	LABORATORY	60.00	0	671	0		20.00
21.00	RESPIRATORY THERAPY	65.00	0	7,411	0		21.00
22.00	PHYSICAL THERAPY	66.00	0	25	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	2,669	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	3	0		24.00
25.00	CLINIC	90.00	0	9,328	0		25.00
26.00	EMERGENCY	91.00	0	77,130	0		26.00
27.00	OTHER	194.00	0	623,235	0		27.00
	TOTALS		0	7,132,380			
	B - IMPLANTS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	32,990	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	50,559	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	20,681	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	242	0		4.00
5.00	NURSERY	43.00	0	2,328	0		5.00
6.00	SKILLED NURSING FACILITY	44.00	0	1,414	0		6.00
7.00	OPERATING ROOM	50.00	0	6,710,692	0		7.00
8.00	RECOVERY ROOM	51.00	0	458	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	28,286	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,201	0		10.00
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	245	0		11.00
12.00	CT SCAN	57.00	0	3,608	0		12.00
13.00	MRI	58.00	0	93	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	757,026	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	85	0		15.00
16.00	ELECTROCARDIOLOGY	69.00	0	4,443	0		16.00
17.00	CLINIC	90.00	0	45,617	0		17.00
18.00	EMERGENCY	91.00	0	31,602	0		18.00
19.00	OTHER	194.00	0	5	0		19.00
	TOTALS		0	7,691,575			
	C - CHARGABLE SUPPLIES						
1.00	ADMINISTRATION & GENERAL	5.06	0	530	0		1.00
2.00	HOUSEKEEPING	9.00	0	3,844	0		2.00
3.00	NURSING ADMINISTRATION	13.00	0	39	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	40,051	0		4.00
5.00	PHARMACY	15.00	0	26,177	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	501	0		6.00
7.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	83	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	529,948	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	94,668	0		9.00
10.00	SUBPROVIDER - IRF	41.00	0	6,984	0		10.00
11.00	NURSERY	43.00	0	26,711	0		11.00
12.00	SKILLED NURSING FACILITY	44.00	0	23,883	0		12.00
13.00	OPERATING ROOM	50.00	0	5,416,785	0		13.00
14.00	RECOVERY ROOM	51.00	0	7,388	0		14.00
15.00	ANESTHESIOLOGY	53.00	0	190,604	0		15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	90,324	0		16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	7,389	0		17.00
18.00	CT SCAN	57.00	0	47,759	0		18.00
19.00	MRI	58.00	0	3,406	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	372,497	0		20.00
21.00	LABORATORY	60.00	0	657	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	93,997	0		22.00

RECLASSIFICATIONS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/29/2018 4:29 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
23.00	PHYSICAL THERAPY	66.00	0	12,223	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	5,992	0		24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,320	0		25.00
26.00	CARDIAC REHABILITATION	76.97	0	316	0		26.00
27.00	CLINIC	90.00	0	20,273	0		27.00
28.00	EMERGENCY	91.00	0	89,899	0		28.00
29.00	OTHER	194.00	0	30,417	0		29.00
	TOTALS		0	7,145,665			
	D - NURSEY						
1.00	ADULTS & PEDIATRICS	30.00	225,795	79,980	0		1.00
	TOTALS		225,795	79,980			
	E - CAFETERIA						
1.00	DIETARY	10.00	846,889	1,497,584	0		1.00
	TOTALS		846,889	1,497,584			
	F - PHYSICIAN DEPR CHAIRMAN						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	959,678	95,417	0		1.00
	TOTALS		959,678	95,417			
	G - SALARY EARNED TIME OFF ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	401,395	0		1.00
	TOTALS		0	401,395			
	H - EQUIP DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,245,011	9		1.00
2.00	ADMINISTRATION & GENERAL	5.06	0	6,872,194	0		2.00
3.00	HOUSEKEEPING	9.00	0	10,390	0		3.00
4.00	DIETARY	10.00	0	52,449	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	428,519	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	37,662	0		6.00
7.00	PHARMACY	15.00	0	37,167	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,516	0		8.00
9.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	5,320	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	655,478	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	17,411	0		11.00
12.00	SUBPROVIDER - IRF	41.00	0	4,372	0		12.00
13.00	NURSERY	43.00	0	21,898	0		13.00
14.00	SKILLED NURSING FACILITY	44.00	0	17,388	0		14.00
15.00	OPERATING ROOM	50.00	0	558,796	0		15.00
16.00	RECOVERY ROOM	51.00	0	14,019	0		16.00
17.00	ANESTHESIOLOGY	53.00	0	1,462	0		17.00
18.00	RADIOLOGY-DIAGNOSTIC	54.00	0	93,663	0		18.00
19.00	RADIOLOGY-THERAPEUTIC	55.00	0	165,247	0		19.00
20.00	MRI	58.00	0	145,298	0		20.00
21.00	CARDIAC CATHETERIZATION	59.00	0	209,078	0		21.00
22.00	LABORATORY	60.00	0	80,954	0		22.00
23.00	RESPIRATORY THERAPY	65.00	0	27,827	0		23.00
24.00	PHYSICAL THERAPY	66.00	0	47,373	0		24.00
25.00	ELECTROCARDIOLOGY	69.00	0	35,046	0		25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	8,036	0		26.00
27.00	CARDIAC REHABILITATION	76.97	0	2,107	0		27.00
28.00	CLINIC	90.00	0	3,196	0		28.00
29.00	EMERGENCY	91.00	0	506,089	0		29.00
30.00	PARTIAL HOSPITALIZATION	91.01	0	252	0		30.00
31.00	OTHER	194.00	0	115,329	0		31.00
	TOTALS		0	15,421,547			
	I - PHONES						
1.00	ADMINISTRATION & GENERAL	5.06	0	157,049	0		1.00
	TOTALS		0	157,049			
	J - PHARMACY RESIDENCY COSTS						
1.00	PHARMACY	15.00	50,270	16,403	0		1.00
	TOTALS		50,270	16,403			
	L - INTERNS AND RESIDENTS SALARY						
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	7,859,270	2,523,137	0		1.00
	TOTALS		7,859,270	2,523,137			
	M - BLOOD RECLASS						
1.00	LABORATORY	60.00	0	11,568	0		1.00
	TOTALS		0	11,568			
500.00	Grand Total: Decreases		9,941,902	42,173,700			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

		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	7,327,666	0	0	0	0	1.00
2.00	Land Improvements	2,447,033	63,733	0	63,733	0	2.00
3.00	Buildings and Fixtures	80,702,716	16,590,150	0	16,590,150	5,950	3.00
4.00	Building Improvements	22,543,500	0	0	0	0	4.00
5.00	Fixed Equipment	31,228,126	1,007,044	0	1,007,044	3,905	5.00
6.00	Movable Equipment	72,083,566	2,370,299	0	2,370,299	206,333	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	216,332,607	20,031,226	0	20,031,226	216,188	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	216,332,607	20,031,226	0	20,031,226	216,188	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	7,327,666	0	1.00
2.00	Land Improvements	2,510,766	0	2.00
3.00	Buildings and Fixtures	97,286,916	0	3.00
4.00	Building Improvements	22,543,500	0	4.00
5.00	Fixed Equipment	32,231,265	0	5.00
6.00	Movable Equipment	74,247,532	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	236,147,645	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	236,147,645	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,245,011	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	5,245,011	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	5,245,011	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	5,245,011	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	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	144,249,041	0	144,249,041	0.666793	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	72,083,566	0	72,083,566	0.333207	0	2.00
3.00	Total (sum of lines 1-2)	216,332,607	0	216,332,607	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	16,229,973	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,229,973	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	885,601	0	0	0	885,601	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	16,229,973	2.00
3.00	Total (sum of lines 1-2)	885,601	0	0	0	17,115,574	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,676,570			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	973,940			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,136,698	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		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-5,000	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		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	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME	B	-633	NURSERY	43.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/29/2018 4:29 pm

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	MISC REVENUE	B	-8,145	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
38.00	MISC INCOME	A	-4,565	CLINIC	90.00	0	38.00
39.00	MOONLIGHTERS	A	-301,127	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	39.00
40.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	40.00
42.00	PHYS FEES	A	-1,400,620	OTHER	194.00	0	42.00
43.02	MISC INCOME	B	1,080	ADULTS & PEDIATRICS	30.00	0	43.02
43.03	MISC INCOME	B	-3,897,999	ADMINISTRATION & GENERAL	5.06	0	43.03
43.04	MISC INCOME	B	-12,900	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	43.04
43.05	MISC INCOME	B	-48,100	PHARMACY	15.00	0	43.05
43.10	MISC INCOME		0		0.00	0	43.10
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	MISC INCOME	B	-4,671	ELECTROENCEPHALOGRAPHY	70.00	0	45.00
46.00	MISC INCOME	B	-553	SKILLED NURSING FACILITY	44.00	0	46.00
47.00	MISC INCOME		0		0.00	0	47.00
48.00	BENEFITS ON PART B DOCS	A	-301,760	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-14,824,321				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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2018 4:29 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	777,909	0	1.00
2.00	5.05	CASHIERING/ACCTS RECEIVABLE	PATIENT ACCOUNTS	4,337,214	0	2.00
3.00	5.02	DATA PROCESSING	IT	2,624,387	0	3.00
3.01	5.03	PURCHASING,RECEIVING&STORES	PURCHASING	166,134	0	3.01
3.02	5.06	ADMINISTRATION & GENERAL	A & G	15,878,364	27,366,792	3.02
3.03	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	857,315	0	3.03
3.04	31.00	INTENSIVE CARE UNIT	EICU	432,303	0	3.04
3.05	2.00	CAP REL COSTS-MVBLE EQUIP	CRC	808,426	0	3.05
3.06	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE INTEREST	885,601	0	3.06
3.07	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,512,252	0	3.07
4.00	60.00	LABORATORY	ALVERNO LAB	7,262,599	7,201,772	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			35,542,504	34,568,564	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		100.00	PRESENCE HEALTH	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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-1 | Date/Time Prepared: 5/29/2018 4:29 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	777,909	0		1.00
2.00	4,337,214	0		2.00
3.00	2,624,387	0		3.00
3.01	166,134	0		3.01
3.02	-11,488,428	0		3.02
3.03	857,315	0		3.03
3.04	432,303	0		3.04
3.05	808,426	9		3.05
3.06	885,601	11		3.06
3.07	1,512,252	0		3.07
4.00	60,827	0		4.00
5.00	973,940			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	SOLE CORPORATE MEMBER		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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/29/2018 4:29 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1,993,538	1,007,859	985,678	179,000	8,518	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	289,535	289,535	0	0	0	2.00
3.00	44.00	SKILLED NURSING FACILITY	26,665	26,665	0	0	0	3.00
4.00	50.00	OPERATING ROOM	1,003,562	1,003,562	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	342,492	342,492	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	991,610	991,610	0	0	0	6.00
7.00	60.00	LABORATORY	45,300	45,300	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	2,285,915	2,285,915	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	361,541	361,541	0	0	0	9.00
10.00	91.00	EMERGENCY	490,618	490,618	0	0	0	10.00
11.00	91.01	PARTIAL HOSPITALIZATION	26,000	26,000	0	0	0	11.00
12.00	5.06	ADMINISTRATION & GENERAL	1,707,737	1,388,533	319,204	179,000	1,800	12.00
200.00			9,564,513	8,259,630	1,304,882		10,318	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	30.00	ADULTS & PEDIATRICS	733,039	36,652	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	0	0	11.00
12.00	5.06	ADMINISTRATION & GENERAL	154,904	7,745	0	0	0	12.00
200.00			887,943	44,397	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	30.00	ADULTS & PEDIATRICS	0	733,039	252,639	1,260,499		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	289,535		2.00
3.00	44.00	SKILLED NURSING FACILITY	0	0	0	26,665		3.00
4.00	50.00	OPERATING ROOM	0	0	0	1,003,562		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	342,492		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	991,610		6.00
7.00	60.00	LABORATORY	0	0	0	45,300		7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	2,285,915		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	361,541		9.00
10.00	91.00	EMERGENCY	0	0	0	490,618		10.00
11.00	91.01	PARTIAL HOSPITALIZATION	0	0	0	26,000		11.00
12.00	5.06	ADMINISTRATION & GENERAL	0	154,904	164,300	1,552,833		12.00
200.00			0	887,943	416,939	8,676,570		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	885,601	885,601				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,229,973		16,229,973			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-391,240	0	0	-391,240		4.00
5.01	00540	NONPATIENT TELEPHONES	157,049	0	0	0	157,049	5.01
5.02	00550	DATA PROCESSING	2,624,387	0	0	0	0	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	166,134	0	0	0	2,540	5.03
5.04	00570	ADMITTING	0	0	0	0	4,515	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	4,337,214	214	3,922	0	7,055	5.05
5.06	00591	ADMINISTRATION & GENERAL	58,254,066	300,705	5,510,852	0	19,190	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,551,080	31,687	580,715	0	6,491	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	735,742	1,943	35,610	0	564	8.00
9.00	00900	HOUSEKEEPING	3,200,472	34,320	628,970	0	847	9.00
10.00	01000	DIETARY	2,217,857	32,738	599,979	0	1,129	10.00
11.00	01100	CAFETERIA	1,207,775	0	0	0	1,693	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,420,366	3,369	61,746	0	6,773	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	683,439	0	0	0	706	14.00
15.00	01500	PHARMACY	3,178,105	6,215	113,890	0	2,822	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,763,253	13,074	239,609	0	5,362	16.00
17.00	01700	SOCIAL SERVICE	1,958,876	0	0	0	2,117	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	10,382,407	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	5,377,664	5,189	95,097	0	7,479	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	257,564	115	2,102	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,480,003	199,688	3,659,583	0	23,988	30.00
31.00	03100	INTENSIVE CARE UNIT	3,889,737	24,475	448,534	0	5,503	31.00
41.00	04100	SUBPROVIDER - IRF	918,197	10,409	190,759	0	3,245	41.00
43.00	04300	NURSERY	2,653,601	6,048	110,847	0	1,129	43.00
44.00	04400	SKILLED NURSING FACILITY	2,594,631	25,979	476,112	0	1,693	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,192,031	68,089	1,247,837	0	11,571	50.00
51.00	05100	RECOVERY ROOM	770,145	3,542	64,914	0	0	51.00
53.00	05300	ANESTHESIOLOGY	206,152	1,503	27,547	0	282	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,527,760	36,096	661,505	0	11,429	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,065,329	9,955	182,444	0	0	55.00
57.00	05700	CT SCAN	536,710	2,659	48,725	0	0	57.00
58.00	05800	MRI	403,614	1,464	26,825	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,128,582	16,853	308,853	0	0	59.00
60.00	06000	LABORATORY	7,320,991	18,680	342,330	0	8,184	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	539,905	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,369,313	5,502	100,838	0	1,975	65.00
66.00	06600	PHYSICAL THERAPY	3,406,726	11,220	205,630	0	3,951	66.00
69.00	06900	ELECTROCARDIOLOGY	573,609	0	0	0	2,258	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	65,351	65	1,192	0	1,834	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,145,317	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,691,575	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,132,380	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	543,869	0	0	0	847	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	73,560	0	0	0	423	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	587,626	931	17,068	0	5,926	90.00
91.00	09100	EMERGENCY	3,395,086	0	0	0	3,528	91.00
91.01	09101	PARTIAL HOSPITALIZATION	206,814	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	213,616,398	872,727	15,994,035	0	157,049	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	4,376,197	12,874	235,938	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	-391,240	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
202.00	TOTAL (sum lines 118 through 201)	217,992,595	885,601	16,229,973	-391,240	157,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	DATA PROCESSING	PURCHASING,RECEIVING&STORES	ADMITTING	CASHIERING/ACCTS RECEIVABLE	Subtotal	
			5.02	5.03	5.04	5.05	5A.05	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	2,624,387					5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	168,674				5.03
5.04	00570	ADMITTING	0	0	4,515			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	4,348,405		5.05
5.06	00591	ADMINISTRATION & GENERAL	2,624,387	1,554	0	0	66,710,754	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	2	0	0	3,169,975	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	773,859	8.00
9.00	00900	HOUSEKEEPING	0	283	0	0	3,864,892	9.00
10.00	01000	DIETARY	0	324	0	0	2,852,027	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,209,468	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	31	0	0	2,492,285	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,517	0	0	685,662	14.00
15.00	01500	PHARMACY	0	2,497	0	0	3,303,529	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54	0	0	2,021,352	16.00
17.00	01700	SOCIAL SERVICE	0	25	0	0	1,961,018	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	10,382,407	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,559	0	0	5,488,988	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	259,781	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	8,460	1,162	781,306	30,154,190	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,221	172	92,302	4,461,944	31.00
41.00	04100	SUBPROVIDER - IRF	0	234	42	22,517	1,145,403	41.00
43.00	04300	NURSERY	0	268	135	72,223	2,844,251	43.00
44.00	04400	SKILLED NURSING FACILITY	0	795	76	40,703	3,139,989	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,742	354	596,021	12,124,645	50.00
51.00	05100	RECOVERY ROOM	0	56	63	69,506	908,226	51.00
53.00	05300	ANESTHESIOLOGY	0	171	90	143,975	379,720	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	362	124	268,564	4,505,840	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	73	4	83,170	2,340,975	55.00
57.00	05700	CT SCAN	0	463	102	158,752	747,411	57.00
58.00	05800	MRI	0	92	51	104,484	536,530	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,006	98	106,871	2,562,263	59.00
60.00	06000	LABORATORY	0	80	429	413,909	8,104,603	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3	32	20,614	560,554	63.00
65.00	06500	RESPIRATORY THERAPY	0	172	120	69,598	1,547,518	65.00
66.00	06600	PHYSICAL THERAPY	0	190	77	50,045	3,677,839	66.00
69.00	06900	ELECTROCARDIOLOGY	0	70	115	132,719	708,771	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8	5	8,645	77,100	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	134,821	200	200,766	7,481,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	159	141,419	7,833,153	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	733	519,069	7,652,182	73.00
74.00	07400	RENAL DIALYSIS	0	0	15	8,383	553,114	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1	0	1,834	75,818	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	107	3	20,292	631,953	90.00
91.00	09100	EMERGENCY	0	607	150	216,844	3,616,215	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	3,874	210,688	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,624,387	167,848	4,511	4,348,405	213,757,996	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	826	4	0	4,625,839	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	-391,240	201.00
202.00		TOTAL (sum lines 118 through 201)	2,624,387	168,674	4,515	4,348,405	217,992,595	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	66,710,754					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,394,260	0	4,564,235			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	340,369	0	16,038	1,130,266		8.00
9.00	00900	HOUSEKEEPING	1,699,907	0	283,267	0	5,848,066	9.00
10.00	01000	DIETARY	1,254,416	0	270,211	0	370,513	10.00
11.00	01100	CAFETERIA	531,964	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,096,189	0	27,808	0	38,130	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	301,577	0	0	0	0	14.00
15.00	01500	PHARMACY	1,453,001	0	51,292	0	70,332	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	889,057	0	107,912	0	147,969	16.00
17.00	01700	SOCIAL SERVICE	862,520	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	4,566,525	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,414,238	0	42,828	0	58,726	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	114,260	0	947	0	1,298	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,262,736	0	1,648,155	434,209	2,259,949	30.00
31.00	03100	INTENSIVE CARE UNIT	1,962,510	0	202,005	13,503	276,988	31.00
41.00	04100	SUBPROVIDER - IRF	503,786	0	85,911	28,267	117,801	41.00
43.00	04300	NURSERY	1,250,995	0	49,922	68,567	68,453	43.00
44.00	04400	SKILLED NURSING FACILITY	1,381,071	0	214,425	67,978	294,019	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,332,819	0	561,984	207,375	770,592	50.00
51.00	05100	RECOVERY ROOM	399,468	0	29,235	15,668	40,087	51.00
53.00	05300	ANESTHESIOLOGY	167,013	0	12,406	0	17,011	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,981,817	0	297,920	118,276	408,507	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,029,638	0	82,167	36,142	112,667	55.00
57.00	05700	CT SCAN	328,736	0	21,944	822	30,090	57.00
58.00	05800	MRI	235,984	0	12,081	0	16,566	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,126,968	0	139,097	29,494	190,730	59.00
60.00	06000	LABORATORY	3,564,672	0	154,174	39	211,403	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	246,550	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	680,649	0	45,414	0	62,272	65.00
66.00	06600	PHYSICAL THERAPY	1,617,635	0	92,609	2,861	126,985	66.00
69.00	06900	ELECTROCARDIOLOGY	311,741	0	0	9,201	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	33,911	0	537	658	736	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,290,436	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,445,279	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,365,682	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	243,278	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	33,347	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	277,954	0	7,687	9,158	10,540	90.00
91.00	09100	EMERGENCY	1,590,531	0	0	85,548	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	92,668	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	64,676,157	0	4,457,976	1,127,766	5,702,364	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	2,034,597	0	106,259	2,500	145,702	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	66,710,754	0	4,564,235	1,130,266	5,848,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	4,747,167					10.00
11.00	01100	CAFETERIA	0	1,741,432				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	18,460	0	3,672,872		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,564	0	482	996,285	14.00
15.00	01500	PHARMACY	0	49,635	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,854	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	23,329	0	532	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	182,024	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	38,290	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	3,198	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,887,603	622,641	0	2,002,231	0	30.00
31.00	03100	INTENSIVE CARE UNIT	131,421	70,914	0	324,461	0	31.00
41.00	04100	SUBPROVIDER - IRF	139,934	27,050	0	94,819	0	41.00
43.00	04300	NURSERY	0	62,546	0	237,159	0	43.00
44.00	04400	SKILLED NURSING FACILITY	588,209	62,037	0	157,102	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	152,142	0	298,896	0	50.00
51.00	05100	RECOVERY ROOM	0	17,441	0	74,557	0	51.00
53.00	05300	ANESTHESIOLOGY	0	4,687	0	25	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	64,961	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	25,209	0	17,664	0	55.00
57.00	05700	CT SCAN	0	12,245	0	0	0	57.00
58.00	05800	MRI	0	9,478	0	38	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	31,110	0	88,515	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	36,175	0	150	0	65.00
66.00	06600	PHYSICAL THERAPY	0	39,073	0	1,388	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,689	0	1,251	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,332	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	479,801	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	516,484	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,149	0	4,024	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	8,538	0	6,604	0	90.00
91.00	09100	EMERGENCY	0	77,729	0	276,332	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	3,629	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,747,167	1,668,129	0	3,586,230	996,285	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	73,303	0	86,642	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,747,167	1,741,432	0	3,672,872	996,285	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	4,927,789					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,168,144				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,847,399			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	569,458	2,103,160	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	67,243	142,178	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	16,404	75,695	0	0	41.00
43.00	04300	NURSERY	0	52,616	208,150	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	29,653	318,216	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	434,210	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	50,636	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	104,888	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	195,653	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	60,591	0	0	0	55.00
57.00	05700	CT SCAN	0	115,653	0	0	0	57.00
58.00	05800	MRI	0	76,118	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	77,857	0	0	0	59.00
60.00	06000	LABORATORY	0	301,539	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	15,018	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	50,703	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	36,459	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	96,688	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,298	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	146,261	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	103,026	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,927,789	378,149	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	6,107	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	1,336	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	14,783	0	0	0	90.00
91.00	09100	EMERGENCY	0	157,974	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	2,823	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,927,789	3,168,144	2,847,399	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,927,789	3,168,144	2,847,399	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	15,130,956					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		8,043,070				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			379,484			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,393,191	6,056,208	0	74,393,731	-17,449,399	30.00
31.00	03100	INTENSIVE CARE UNIT	977,167	519,427	0	9,149,761	-1,496,594	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	2,235,070	0	41.00
43.00	04300	NURSERY	0	0	0	4,842,659	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	6,252,699	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,624,386	863,465	0	22,370,514	-2,487,851	50.00
51.00	05100	RECOVERY ROOM	0	0	0	1,535,318	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	685,750	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,780	161,479	0	8,038,233	-465,259	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,705,053	0	55.00
57.00	05700	CT SCAN	0	0	0	1,256,901	0	57.00
58.00	05800	MRI	0	0	0	886,795	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	4,246,034	0	59.00
60.00	06000	LABORATORY	6,133	3,260	0	12,345,823	-9,393	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	822,122	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,422,881	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,594,849	0	66.00
69.00	06900	ELECTROCARDIOLOGY	120,204	63,896	0	1,324,441	-184,100	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	120,572	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,397,602	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,897,942	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	379,484	16,703,286	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	802,499	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	115,674	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,630	5,651	0	983,498	-16,281	90.00
91.00	09100	EMERGENCY	695,465	369,684	0	6,869,478	-1,065,149	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	309,808	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,130,956	8,043,070	379,484	211,308,993	-23,174,026	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	7,074,842	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-391,240	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	INTERNS & RESIDENTS					
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
202.00	TOTAL (sum lines 118 through 201)	15,130,956	8,043,070	379,484	217,992,595	-23,174,026	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	Total		
			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
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING,RECEIVING&STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATION & GENERAL			5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	56,944,332		30.00
31.00	03100	INTENSIVE CARE UNIT	7,653,167		31.00
41.00	04100	SUBPROVIDER - IRF	2,235,070		41.00
43.00	04300	NURSERY	4,842,659		43.00
44.00	04400	SKILLED NURSING FACILITY	6,252,699		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	19,882,663		50.00
51.00	05100	RECOVERY ROOM	1,535,318		51.00
53.00	05300	ANESTHESIOLOGY	685,750		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,572,974		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,705,053		55.00
57.00	05700	CT SCAN	1,256,901		57.00
58.00	05800	MRI	886,795		58.00
59.00	05900	CARDIAC CATHETERIZATION	4,246,034		59.00
60.00	06000	LABORATORY	12,336,430		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	822,122		63.00
65.00	06500	RESPIRATORY THERAPY	2,422,881		65.00
66.00	06600	PHYSICAL THERAPY	5,594,849		66.00
69.00	06900	ELECTROCARDIOLOGY	1,140,341		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	120,572		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,397,602		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,897,942		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,703,286		73.00
74.00	07400	RENAL DIALYSIS	802,499		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		76.00
76.97	07697	CARDIAC REHABILITATION	115,674		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	967,217		90.00
91.00	09100	EMERGENCY	5,804,329		91.00
91.01	09101	PARTIAL HOSPITALIZATION	309,808		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	188,134,967		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	7,074,842		194.00
194.01	07951	LAKESHORE GUEST UNIT	0		194.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	-391,240		201.00
202.00		TOTAL (sum lines 118 through 201)	194,818,569		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	0	0	5.01
5.02	00550	DATA PROCESSING	0	0	0	0	0	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	0	0	0	0	5.03
5.04	00570	ADMITTING	0	0	0	0	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	214	3,922	4,136	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	8,743,741	300,705	5,510,852	14,555,298	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	216	31,687	580,715	612,618	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	408	1,943	35,610	37,961	0	8.00
9.00	00900	HOUSEKEEPING	408	34,320	628,970	663,698	0	9.00
10.00	01000	DIETARY	14,138	32,738	599,979	646,855	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,974	3,369	61,746	70,089	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	57,196	0	0	57,196	0	14.00
15.00	01500	PHARMACY	122,705	6,215	113,890	242,810	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,789	13,074	239,609	257,472	0	16.00
17.00	01700	SOCIAL SERVICE	711	0	0	711	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	16,781	5,189	95,097	117,067	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	115	2,102	2,217	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	52,760	199,688	3,659,583	3,912,031	0	30.00
31.00	03100	INTENSIVE CARE UNIT	29,663	24,475	448,534	502,672	0	31.00
41.00	04100	SUBPROVIDER - IRF	682	10,409	190,759	201,850	0	41.00
43.00	04300	NURSERY	799	6,048	110,847	117,694	0	43.00
44.00	04400	SKILLED NURSING FACILITY	17,842	25,979	476,112	519,933	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	269,063	68,089	1,247,837	1,584,989	0	50.00
51.00	05100	RECOVERY ROOM	1,486	3,542	64,914	69,942	0	51.00
53.00	05300	ANESTHESIOLOGY	4,683	1,503	27,547	33,733	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,756	36,096	661,505	703,357	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	13,764	9,955	182,444	206,163	0	55.00
57.00	05700	CT SCAN	88	2,659	48,725	51,472	0	57.00
58.00	05800	MRI	0	1,464	26,825	28,289	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,256	16,853	308,853	331,962	0	59.00
60.00	06000	LABORATORY	13,350	18,680	342,330	374,360	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,956	5,502	100,838	110,296	0	65.00
66.00	06600	PHYSICAL THERAPY	387,125	11,220	205,630	603,975	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,183	0	0	6,183	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,995	65	1,192	3,252	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	58	0	0	58	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,813	931	17,068	24,812	0	90.00
91.00	09100	EMERGENCY	7,910	0	0	7,910	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	1,868	0	0	1,868	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,798,167	872,727	15,994,035	26,664,929	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	720,494	12,874	235,938	969,306	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
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)	10,518,661	885,601	16,229,973	27,634,235	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING,RECEIVING&STORES	ADMITTING	CASHIERING/ACCTS RECEIVABLE	
			5.01	5.02	5.03	5.04	5.05	
		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
5.01	00540	NONPATIENT TELEPHONES	0					5.01
5.02	00550	DATA PROCESSING	0	0				5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	0	0			5.03
5.04	00570	ADMITTING	0	0	0	0		5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	0	0	4,136	5.05
5.06	00591	ADMINISTRATION & GENERAL	0	0	0	0	0	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	0	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	443	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	96	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	23	41.00
43.00	04300	NURSERY	0	0	0	0	75	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	42	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	617	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	72	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	278	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	86	55.00
57.00	05700	CT SCAN	0	0	0	0	164	57.00
58.00	05800	MRI	0	0	0	0	108	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	111	59.00
60.00	06000	LABORATORY	0	0	0	0	429	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	21	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	72	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	52	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	137	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	9	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	208	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	537	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	9	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	2	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	21	90.00
91.00	09100	EMERGENCY	0	0	0	0	225	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	4	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	4,136	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	0	0	4,136	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	ADMINISTRATION & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.06	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL	14,555,298					5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	304,207	0	916,825			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,263	0	3,222	115,446		8.00
9.00	00900	HOUSEKEEPING	370,894	0	56,900	0	1,091,492	9.00
10.00	01000	DIETARY	273,695	0	54,278	0	69,153	10.00
11.00	01100	CAFETERIA	116,067	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	239,172	0	5,586	0	7,117	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,800	0	0	0	0	14.00
15.00	01500	PHARMACY	317,023	0	10,303	0	13,127	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	193,979	0	21,676	0	27,617	16.00
17.00	01700	SOCIAL SERVICE	188,189	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	996,348	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	526,751	0	8,603	0	10,961	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	24,930	0	190	0	242	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,893,733	0	331,066	44,352	421,800	30.00
31.00	03100	INTENSIVE CARE UNIT	428,190	0	40,577	1,379	51,698	31.00
41.00	04100	SUBPROVIDER - IRF	109,919	0	17,257	2,887	21,987	41.00
43.00	04300	NURSERY	272,949	0	10,028	7,003	12,776	43.00
44.00	04400	SKILLED NURSING FACILITY	301,329	0	43,072	6,943	54,876	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,163,542	0	112,887	21,181	143,824	50.00
51.00	05100	RECOVERY ROOM	87,158	0	5,873	1,600	7,482	51.00
53.00	05300	ANESTHESIOLOGY	36,440	0	2,492	0	3,175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	432,403	0	59,844	12,081	76,244	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	224,652	0	16,505	3,692	21,028	55.00
57.00	05700	CT SCAN	71,725	0	4,408	84	5,616	57.00
58.00	05800	MRI	51,488	0	2,427	0	3,092	58.00
59.00	05900	CARDIAC CATHETERIZATION	245,888	0	27,941	3,013	35,598	59.00
60.00	06000	LABORATORY	777,758	0	30,969	4	39,457	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	53,794	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	148,508	0	9,122	0	11,623	65.00
66.00	06600	PHYSICAL THERAPY	352,944	0	18,603	292	23,701	66.00
69.00	06900	ELECTROCARDIOLOGY	68,017	0	0	940	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,399	0	108	67	137	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	717,924	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	751,709	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	734,342	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	53,080	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,276	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	60,645	0	1,544	935	1,967	90.00
91.00	09100	EMERGENCY	347,030	0	0	8,738	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	20,219	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,111,379	0	895,481	115,191	1,064,298	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	443,919	0	21,344	255	27,194	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,555,298	0	916,825	115,446	1,091,492	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	1,043,981					10.00
11.00	01100	CAFETERIA	0	116,067				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	1,230	0	323,194		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	571	0	42	123,609	14.00
15.00	01500	PHARMACY	0	3,308	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	124	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,555	0	47	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	12,132	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,552	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	213	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	854,948	41,499	0	176,187	0	30.00
31.00	03100	INTENSIVE CARE UNIT	28,902	4,726	0	28,551	0	31.00
41.00	04100	SUBPROVIDER - IRF	30,774	1,803	0	8,344	0	41.00
43.00	04300	NURSERY	0	4,169	0	20,869	0	43.00
44.00	04400	SKILLED NURSING FACILITY	129,357	4,135	0	13,824	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	10,140	0	26,301	0	50.00
51.00	05100	RECOVERY ROOM	0	1,162	0	6,561	0	51.00
53.00	05300	ANESTHESIOLOGY	0	312	0	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,330	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,680	0	1,554	0	55.00
57.00	05700	CT SCAN	0	816	0	0	0	57.00
58.00	05800	MRI	0	632	0	3	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,073	0	7,789	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,411	0	13	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,604	0	122	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	846	0	110	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	89	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	59,528	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	64,081	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	77	0	354	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	569	0	581	0	90.00
91.00	09100	EMERGENCY	0	5,181	0	24,316	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	242	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,043,981	111,181	0	315,570	123,609	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	4,886	0	7,624	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,043,981	116,067	0	323,194	123,609	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	586,571					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	500,868				16.00
17.00	01700	SOCIAL SERVICE	0	0	190,502			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	90,162	140,710			30.00
31.00	03100	INTENSIVE CARE UNIT	0	10,627	9,512			31.00
41.00	04100	SUBPROVIDER - IRF	0	2,593	5,064			41.00
43.00	04300	NURSERY	0	8,316	13,926			43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,686	21,290			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,624	0			50.00
51.00	05100	RECOVERY ROOM	0	8,003	0			51.00
53.00	05300	ANESTHESIOLOGY	0	16,577	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,922	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	9,576	0			55.00
57.00	05700	CT SCAN	0	18,278	0			57.00
58.00	05800	MRI	0	12,030	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	12,305	0			59.00
60.00	06000	LABORATORY	0	47,657	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,373	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	8,013	0			65.00
66.00	06600	PHYSICAL THERAPY	0	5,762	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	15,281	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	995	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,116	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,283	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	586,571	59,764	0			73.00
74.00	07400	RENAL DIALYSIS	0	965	0			74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	211	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,336	0			90.00
91.00	09100	EMERGENCY	0	24,967	0			91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	446	0			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	586,571	500,868	190,502	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0			194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0			194.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	586,571	500,868	190,502	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,008,480					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		665,934				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			27,792			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				8,906,931	0	30.00
31.00	03100	INTENSIVE CARE UNIT				1,106,930	0	31.00
41.00	04100	SUBPROVIDER - IRF				402,501	0	41.00
43.00	04300	NURSERY				467,805	0	43.00
44.00	04400	SKILLED NURSING FACILITY				1,099,487	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				3,132,105	0	50.00
51.00	05100	RECOVERY ROOM				187,853	0	51.00
53.00	05300	ANESTHESIOLOGY				92,880	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				1,319,459	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				484,936	0	55.00
57.00	05700	CT SCAN				152,563	0	57.00
58.00	05800	MRI				98,069	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				666,680	0	59.00
60.00	06000	LABORATORY				1,270,634	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				56,188	0	63.00
65.00	06500	RESPIRATORY THERAPY				290,058	0	65.00
66.00	06600	PHYSICAL THERAPY				1,008,055	0	66.00
69.00	06900	ELECTROCARDIOLOGY				91,514	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				12,056	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				800,776	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				832,219	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				1,381,214	0	73.00
74.00	07400	RENAL DIALYSIS				54,054	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER				0	0	76.00
76.97	07697	CARDIAC REHABILITATION				7,978	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC				93,410	0	90.00
91.00	09100	EMERGENCY				418,367	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION				22,779	0	91.01
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	0	0	24,457,501	0	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER				1,474,528	0	194.00
194.01	07951	LAKESHORE GUEST UNIT				0	0	194.01
200.00		Cross Foot Adjustments	1,008,480	665,934	27,792	1,702,206	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	INTERNS & RESIDENTS					
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
202.00	TOTAL (sum lines 118 through 201)	1,008,480	665,934	27,792	27,634,235	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	Total		
			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
5.01	00540	NONPATIENT TELEPHONES			5.01
5.02	00550	DATA PROCESSING			5.02
5.03	00560	PURCHASING,RECEIVING&STORES			5.03
5.04	00570	ADMITTING			5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE			5.05
5.06	00591	ADMINISTRATION & GENERAL			5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	8,906,931		30.00
31.00	03100	INTENSIVE CARE UNIT	1,106,930		31.00
41.00	04100	SUBPROVIDER - IRF	402,501		41.00
43.00	04300	NURSERY	467,805		43.00
44.00	04400	SKILLED NURSING FACILITY	1,099,487		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	3,132,105		50.00
51.00	05100	RECOVERY ROOM	187,853		51.00
53.00	05300	ANESTHESIOLOGY	92,880		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,319,459		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	484,936		55.00
57.00	05700	CT SCAN	152,563		57.00
58.00	05800	MRI	98,069		58.00
59.00	05900	CARDIAC CATHETERIZATION	666,680		59.00
60.00	06000	LABORATORY	1,270,634		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	56,188		63.00
65.00	06500	RESPIRATORY THERAPY	290,058		65.00
66.00	06600	PHYSICAL THERAPY	1,008,055		66.00
69.00	06900	ELECTROCARDIOLOGY	91,514		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,056		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	800,776		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	832,219		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,381,214		73.00
74.00	07400	RENAL DIALYSIS	54,054		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		76.00
76.97	07697	CARDIAC REHABILITATION	7,978		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	93,410		90.00
91.00	09100	EMERGENCY	418,367		91.00
91.01	09101	PARTIAL HOSPITALIZATION	22,779		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,457,501		118.00
		NONREIMBURSABLE COST CENTERS			
194.00	07950	OTHER	1,474,528		194.00
194.01	07951	LAKESHORE GUEST UNIT	0		194.01
200.00		Cross Foot Adjustments	1,702,206		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	27,634,235		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	517,294					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		517,294				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	75,468,098			4.00
5.01	00540	NONPATIENT TELEPHONES	0	0	0	1,113		5.01
5.02	00550	DATA PROCESSING	0	0	0	0	100	5.02
5.03	00560	PURCHASING,RECEIVING&STORES	0	0	0	18	0	5.03
5.04	00570	ADMITTING	0	0	0	32	0	5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	125	125	0	50	0	5.05
5.06	00591	ADMINISTRATION & GENERAL	175,646	175,646	5,918,246	136	100	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	18,509	18,509	0	46	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	113,169	4	0	8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	1,556,405	6	0	9.00
10.00	01000	DIETARY	19,123	19,123	864,368	8	0	10.00
11.00	01100	CAFETERIA	0	0	846,889	12	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	1,281,296	48	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	224,085	5	0	14.00
15.00	01500	PHARMACY	3,630	3,630	2,317,021	20	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	71,360	38	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,414,789	15	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	7,859,270	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,031	3,031	2,911,646	53	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	67	67	205,965	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,641	116,641	19,283,320	170	0	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	2,524,009	39	0	31.00
41.00	04100	SUBPROVIDER - IRF	6,080	6,080	723,694	23	0	41.00
43.00	04300	NURSERY	3,533	3,533	2,161,639	8	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	1,974,912	12	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,772	39,772	5,795,902	82	0	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	636,682	0	0	51.00
53.00	05300	ANESTHESIOLOGY	878	878	126,807	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	2,551,599	81	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	1,350,798	0	0	55.00
57.00	05700	CT SCAN	1,553	1,553	416,062	0	0	57.00
58.00	05800	MRI	855	855	322,551	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	1,175,246	0	0	59.00
60.00	06000	LABORATORY	10,911	10,911	0	58	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	952,051	14	0	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	2,363,722	28	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	354,134	16	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	53,021	13	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
74.00	07400	RENAL DIALYSIS	0	0	0	6	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	62,600	3	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	544	544	472,870	42	0	90.00
91.00	09100	EMERGENCY	0	0	2,488,615	25	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	186,110	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	509,774	509,774	71,560,853	1,113	100	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	7,520	7,520	3,907,245	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (TIME SPENT)	
			1.00	2.00	4.00	5.01	5.02	
202.00		Cost to be allocated (per Wkst. B, Part I)	885,601	16,229,973	-391,240	157,049	2,624,387	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.711988	31.374756	0.000000	141.104223	26,243.870000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	PURCHASING,RECEIVING&STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES	8,939,414					5.03
5.04	00570	ADMITTING	0	520,932,388				5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE	0	0	900,496,892			5.05
5.06	00591	ADMINISTRATION & GENERAL	82,369	0	0	-66,710,754	151,673,081	5.06
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	110	0	0	0	3,169,975	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	773,859	8.00
9.00	00900	HOUSEKEEPING	15,008	0	0	0	3,864,892	9.00
10.00	01000	DIETARY	17,180	0	0	0	2,852,027	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,209,468	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,620	0	0	0	2,492,285	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,381	0	0	0	685,662	14.00
15.00	01500	PHARMACY	132,317	0	0	0	3,303,529	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,871	0	0	0	2,021,352	16.00
17.00	01700	SOCIAL SERVICE	1,301	0	0	0	1,961,018	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	10,382,407	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	188,639	0	0	0	5,488,988	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	259,781	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	448,359	148,171,800	161,814,408	0	30,154,190	30.00
31.00	03100	INTENSIVE CARE UNIT	64,727	19,114,054	19,114,054	0	4,461,944	31.00
41.00	04100	SUBPROVIDER - IRF	12,407	4,662,942	4,662,942	0	1,145,403	41.00
43.00	04300	NURSERY	14,213	14,956,201	14,956,201	0	2,844,251	43.00
44.00	04400	SKILLED NURSING FACILITY	42,123	8,428,894	8,428,894	0	3,139,989	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	463,322	39,309,681	123,425,308	0	12,124,645	50.00
51.00	05100	RECOVERY ROOM	2,970	6,980,259	14,393,519	0	908,226	51.00
53.00	05300	ANESTHESIOLOGY	9,064	10,046,304	29,814,617	0	379,720	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,179	13,789,006	55,614,736	0	4,505,840	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,871	499,253	17,223,096	0	2,340,975	55.00
57.00	05700	CT SCAN	24,561	11,381,936	32,874,663	0	747,411	57.00
58.00	05800	MRI	4,853	5,708,685	21,636,828	0	536,530	58.00
59.00	05900	CARDIAC CATHETERIZATION	53,292	10,935,493	22,131,008	0	2,562,263	59.00
60.00	06000	LABORATORY	4,221	47,721,505	85,713,160	0	8,104,603	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	153	3,596,399	4,268,801	0	560,554	63.00
65.00	06500	RESPIRATORY THERAPY	9,091	13,370,593	14,412,414	0	1,547,518	65.00
66.00	06600	PHYSICAL THERAPY	10,086	8,527,619	10,363,455	0	3,677,839	66.00
69.00	06900	ELECTROCARDIOLOGY	3,725	12,831,153	27,483,752	0	708,771	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	438	516,374	1,790,213	0	77,100	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,145,317	22,188,091	41,575,022	0	7,481,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,678,062	29,285,306	0	7,833,153	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	81,484,888	107,489,907	0	7,652,182	73.00
74.00	07400	RENAL DIALYSIS	0	1,611,639	1,735,873	0	553,114	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	38	0	379,692	0	75,818	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,667	299,695	4,202,092	0	631,953	90.00
91.00	09100	EMERGENCY	32,191	16,691,969	44,904,626	0	3,616,215	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	2,210	802,305	0	210,688	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,895,664	520,504,705	900,496,892	-66,710,754	147,047,242	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	43,750	427,683	0	0	4,625,839	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	168,674	4,515	4,348,405		66,710,754	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.018869	0.000009	0.004829		0.439833	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	PURCHASING,RECEIVING&STORES (SUPPLY EXPENSE)	ADMITTING (INPATIENT REVENUE)	CASHIERING/ACCTS RECEIVABLE (GROSS REVENUE)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	
			5.03	5.04	5.05	5A.06	5.06	
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	4,136		14,555,298	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000005		0.095965	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
6.00	00600	MAINTENANCE & REPAIRS	341,523					6.00
7.00	00700	OPERATION OF PLANT	18,509	323,014				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,135	1,135	1,075,109			8.00
9.00	00900	HOUSEKEEPING	20,047	20,047	0	301,832		9.00
10.00	01000	DIETARY	19,123	19,123	0	19,123	150,556	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,968	1,968	0	1,968	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	3,630	3,630	0	3,630	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,637	7,637	0	7,637	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,031	3,031	0	3,031	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	67	67	0	67	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	116,641	116,641	413,020	116,641	123,295	30.00
31.00	03100	INTENSIVE CARE UNIT	14,296	14,296	12,844	14,296	4,168	31.00
41.00	04100	SUBPROVIDER - IRF	6,080	6,080	26,888	6,080	4,438	41.00
43.00	04300	NURSERY	3,533	3,533	65,221	3,533	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,175	15,175	64,661	15,175	18,655	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,772	39,772	197,255	39,772	0	50.00
51.00	05100	RECOVERY ROOM	2,069	2,069	14,903	2,069	0	51.00
53.00	05300	ANESTHESIOLOGY	878	878	0	878	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,084	21,084	112,504	21,084	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,815	5,815	34,378	5,815	0	55.00
57.00	05700	CT SCAN	1,553	1,553	782	1,553	0	57.00
58.00	05800	MRI	855	855	0	855	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,844	9,844	28,055	9,844	0	59.00
60.00	06000	LABORATORY	10,911	10,911	37	10,911	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,214	3,214	0	3,214	0	65.00
66.00	06600	PHYSICAL THERAPY	6,554	6,554	2,721	6,554	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	8,752	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38	38	626	38	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	544	544	8,711	544	0	90.00
91.00	09100	EMERGENCY	0	0	81,373	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	334,003	315,494	1,072,731	294,312	150,556	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	7,520	7,520	2,378	7,520	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	4,564,235	1,130,266	5,848,066	4,747,167	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	14.130146	1.051304	19.375235	31.530905	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (LAUNDRY POUNDS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED))	
		6.00	7.00	8.00	9.00	10.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	916,825	115,446	1,091,492	1,043,981	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	2.838344	0.107381	3.616224	6.934171	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	CAFETERIA (MEALS SERVED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS GHRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY (COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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	133,393					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,414	0	1,174,623			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	656	0	154	14,836,892		14.00
15.00	01500	PHARMACY	3,802	0	0	0	7,132,380	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	142	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,787	0	170	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	13,943	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,933	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	245	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,694	0	640,335	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,432	0	103,766	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	2,072	0	30,324	0	0	41.00
43.00	04300	NURSERY	4,791	0	75,846	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,752	0	50,243	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,654	0	95,590	0	0	50.00
51.00	05100	RECOVERY ROOM	1,336	0	23,844	0	0	51.00
53.00	05300	ANESTHESIOLOGY	359	0	8	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,976	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,931	0	5,649	0	0	55.00
57.00	05700	CT SCAN	938	0	0	0	0	57.00
58.00	05800	MRI	726	0	12	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,383	0	28,308	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,771	0	48	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,993	0	444	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	972	0	400	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	102	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,145,317	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,691,575	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,132,380	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	88	0	1,287	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	654	0	2,112	0	0	90.00
91.00	09100	EMERGENCY	5,954	0	88,374	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	278	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,778	0	1,146,914	14,836,892	7,132,380	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	5,615	0	27,709	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,741,432	0	3,672,872	996,285	4,927,789	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	CAFETERIA (MEALS SERVED))	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS GHRS))	CENTRAL SERVICES & SUPPLY (SUPPLY EXPENSE)	PHARMACY (COSTED REQUIS))	
		11.00	12.00	13.00	14.00	15.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	13.054898	0.000000	3.126852	0.067149	0.690904	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	116,067	0	323,194	123,609	586,571	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.870113	0.000000	0.275147	0.008331	0.082241	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
		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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00560	PURCHASING,RECEIVING&STORES						5.03
5.04	00570	ADMITTING						5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE						5.05
5.06	00591	ADMINISTRATION & GENERAL						5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	900,496,892					16.00
17.00	01700	SOCIAL SERVICE	0	66,770				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			37,008	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	161,814,408	49,318	0	0	27,866	30.00
31.00	03100	INTENSIVE CARE UNIT	19,114,054	3,334	0	0	2,390	31.00
41.00	04100	SUBPROVIDER - IRF	4,662,942	1,775	0	0	0	41.00
43.00	04300	NURSERY	14,956,201	4,881	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	8,428,894	7,462	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	123,425,308	0	0	0	3,973	50.00
51.00	05100	RECOVERY ROOM	14,393,519	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	29,814,617	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,614,736	0	0	0	743	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	17,223,096	0	0	0	0	55.00
57.00	05700	CT SCAN	32,874,663	0	0	0	0	57.00
58.00	05800	MRI	21,636,828	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	22,131,008	0	0	0	0	59.00
60.00	06000	LABORATORY	85,713,160	0	0	0	15	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,268,801	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	14,412,414	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,363,455	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	27,483,752	0	0	0	294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,790,213	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	41,575,022	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,285,306	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,489,907	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,735,873	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	379,692	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,202,092	0	0	0	26	90.00
91.00	09100	EMERGENCY	44,904,626	0	0	0	1,701	91.00
91.01	09101	PARTIAL HOSPITALIZATION	802,305	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	900,496,892	66,770	0	0	37,008	118.00
		NONREIMBURSABLE COST CENTERS						
194.00	07950	OTHER	0	0	0	0	0	194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,168,144	2,847,399	0	0	15,130,956	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003518	42.644885	0.000000	0.000000	408.856355	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	500,868	190,502	0	0	1,008,480	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000556	2.853108	0.000000	0.000000	27.250324	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME))	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		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
5.01	00540	NONPATIENT TELEPHONES				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00560	PURCHASING,RECEIVING&STORES				5.03
5.04	00570	ADMITTING				5.04
5.05	00580	CASHIERING/ACCTS RECEIVABLE				5.05
5.06	00591	ADMINISTRATION & GENERAL				5.06
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
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	37,008			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	27,866	0		30.00
31.00	03100	INTENSIVE CARE UNIT	2,390	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,973	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	743	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	15	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	294	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	100		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	26	0		90.00
91.00	09100	EMERGENCY	1,701	0		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,008	100		118.00
		NONREIMBURSABLE COST CENTERS				
194.00	07950	OTHER	0	0		194.00
194.01	07951	LAKESHORE GUEST UNIT	0	0		194.01
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME))	PARAMED ED PRGM (ASSIGNED TIME)					
			22.00	23.00					
202.00		Cost to be allocated (per Wkst. B, Part I)	8,043,070	379,484					202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	217.333279	3,794.840000					203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	665,934	27,792					204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.994326	277.920000					205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:29 pm

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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	56,944,332		56,944,332	252,639	57,196,971	30.00
31.00	03100	INTENSIVE CARE UNIT	7,653,167		7,653,167	0	7,653,167	31.00
41.00	04100	SUBPROVIDER - IRF	2,235,070		2,235,070	0	2,235,070	41.00
43.00	04300	NURSERY	4,842,659		4,842,659	0	4,842,659	43.00
44.00	04400	SKILLED NURSING FACILITY	6,252,699		6,252,699	0	6,252,699	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,882,663		19,882,663	0	19,882,663	50.00
51.00	05100	RECOVERY ROOM	1,535,318		1,535,318	0	1,535,318	51.00
53.00	05300	ANESTHESIOLOGY	685,750		685,750	0	685,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,572,974		7,572,974	0	7,572,974	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,705,053		3,705,053	0	3,705,053	55.00
57.00	05700	CT SCAN	1,256,901		1,256,901	0	1,256,901	57.00
58.00	05800	MRI	886,795		886,795	0	886,795	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,246,034		4,246,034	0	4,246,034	59.00
60.00	06000	LABORATORY	12,336,430		12,336,430	0	12,336,430	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	822,122		822,122	0	822,122	63.00
65.00	06500	RESPIRATORY THERAPY	2,422,881	0	2,422,881	0	2,422,881	65.00
66.00	06600	PHYSICAL THERAPY	5,594,849	0	5,594,849	0	5,594,849	66.00
69.00	06900	ELECTROCARDIOLOGY	1,140,341		1,140,341	0	1,140,341	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	120,572		120,572	0	120,572	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,397,602		11,397,602	0	11,397,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,897,942		11,897,942	0	11,897,942	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,703,286		16,703,286	0	16,703,286	73.00
74.00	07400	RENAL DIALYSIS	802,499		802,499	0	802,499	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	115,674		115,674	0	115,674	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	967,217		967,217	0	967,217	90.00
91.00	09100	EMERGENCY	5,804,329		5,804,329	0	5,804,329	91.00
91.01	09101	PARTIAL HOSPITALIZATION	309,808		309,808	0	309,808	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,948,552		4,948,552		4,948,552	92.00
200.00		Subtotal (see instructions)	193,083,519	0	193,083,519	252,639	193,336,158	200.00
201.00		Less Observation Beds	4,948,552		4,948,552		4,948,552	201.00
202.00		Total (see instructions)	188,134,967	0	188,134,967	252,639	188,387,606	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	145,232,750		145,232,750			30.00
31.00	03100	INTENSIVE CARE UNIT	19,114,054		19,114,054			31.00
41.00	04100	SUBPROVIDER - IRF	4,662,942		4,662,942			41.00
43.00	04300	NURSERY	14,956,201		14,956,201			43.00
44.00	04400	SKILLED NURSING FACILITY	8,428,894		8,428,894			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,309,681	84,115,627	123,425,308	0.161091	0.000000	50.00
51.00	05100	RECOVERY ROOM	6,980,259	7,413,260	14,393,519	0.106667	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	10,046,304	19,768,313	29,814,617	0.023000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,789,006	41,825,730	55,614,736	0.136168	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	499,253	16,723,843	17,223,096	0.215121	0.000000	55.00
57.00	05700	CT SCAN	11,381,936	21,492,727	32,874,663	0.038233	0.000000	57.00
58.00	05800	MRI	5,708,685	15,928,143	21,636,828	0.040985	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,935,493	11,195,515	22,131,008	0.191859	0.000000	59.00
60.00	06000	LABORATORY	47,721,505	37,991,655	85,713,160	0.143927	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,596,399	672,402	4,268,801	0.192589	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	13,370,593	1,041,821	14,412,414	0.168111	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,527,619	1,835,836	10,363,455	0.539863	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,831,153	14,652,599	27,483,752	0.041491	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	516,374	1,273,839	1,790,213	0.067351	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,188,091	19,386,931	41,575,022	0.274145	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,678,062	11,607,244	29,285,306	0.406277	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,484,888	26,005,019	107,489,907	0.155394	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,611,639	124,234	1,735,873	0.462303	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	379,692	379,692	0.304652	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	299,695	3,902,397	4,202,092	0.230175	0.000000	90.00
91.00	09100	EMERGENCY	16,691,969	28,212,657	44,904,626	0.129259	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	2,210	800,095	802,305	0.386147	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,939,050	13,642,608	16,581,658	0.298435	0.000000	92.00
200.00		Subtotal (see instructions)	520,504,705	379,992,187	900,496,892			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	520,504,705	379,992,187	900,496,892			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.161091		50.00
51.00	05100	RECOVERY ROOM	0.106667		51.00
53.00	05300	ANESTHESIOLOGY	0.023000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136168		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.215121		55.00
57.00	05700	CT SCAN	0.038233		57.00
58.00	05800	MRI	0.040985		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191859		59.00
60.00	06000	LABORATORY	0.143927		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.192589		63.00
65.00	06500	RESPIRATORY THERAPY	0.168111		65.00
66.00	06600	PHYSICAL THERAPY	0.539863		66.00
69.00	06900	ELECTROCARDIOLOGY	0.041491		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.067351		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.274145		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406277		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.155394		73.00
74.00	07400	RENAL DIALYSIS	0.462303		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.304652		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.230175		90.00
91.00	09100	EMERGENCY	0.129259		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.386147		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298435		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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	56,944,332		56,944,332	252,639	57,196,971	30.00
31.00	03100	INTENSIVE CARE UNIT	7,653,167		7,653,167	0	7,653,167	31.00
41.00	04100	SUBPROVIDER - IRF	2,235,070		2,235,070	0	2,235,070	41.00
43.00	04300	NURSERY	4,842,659		4,842,659	0	4,842,659	43.00
44.00	04400	SKILLED NURSING FACILITY	6,252,699		6,252,699	0	6,252,699	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,882,663		19,882,663	0	19,882,663	50.00
51.00	05100	RECOVERY ROOM	1,535,318		1,535,318	0	1,535,318	51.00
53.00	05300	ANESTHESIOLOGY	685,750		685,750	0	685,750	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,572,974		7,572,974	0	7,572,974	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,705,053		3,705,053	0	3,705,053	55.00
57.00	05700	CT SCAN	1,256,901		1,256,901	0	1,256,901	57.00
58.00	05800	MRI	886,795		886,795	0	886,795	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,246,034		4,246,034	0	4,246,034	59.00
60.00	06000	LABORATORY	12,336,430		12,336,430	0	12,336,430	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	822,122		822,122	0	822,122	63.00
65.00	06500	RESPIRATORY THERAPY	2,422,881	0	2,422,881	0	2,422,881	65.00
66.00	06600	PHYSICAL THERAPY	5,594,849	0	5,594,849	0	5,594,849	66.00
69.00	06900	ELECTROCARDIOLOGY	1,140,341		1,140,341	0	1,140,341	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	120,572		120,572	0	120,572	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,397,602		11,397,602	0	11,397,602	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,897,942		11,897,942	0	11,897,942	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,703,286		16,703,286	0	16,703,286	73.00
74.00	07400	RENAL DIALYSIS	802,499		802,499	0	802,499	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	115,674		115,674	0	115,674	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	967,217		967,217	0	967,217	90.00
91.00	09100	EMERGENCY	5,804,329		5,804,329	0	5,804,329	91.00
91.01	09101	PARTIAL HOSPITALIZATION	309,808		309,808	0	309,808	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,948,552		4,948,552		4,948,552	92.00
200.00		Subtotal (see instructions)	193,083,519	0	193,083,519	252,639	193,336,158	200.00
201.00		Less Observation Beds	4,948,552		4,948,552		4,948,552	201.00
202.00		Total (see instructions)	188,134,967	0	188,134,967	252,639	188,387,606	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	145,232,750		145,232,750			30.00
31.00	03100	INTENSIVE CARE UNIT	19,114,054		19,114,054			31.00
41.00	04100	SUBPROVIDER - IRF	4,662,942		4,662,942			41.00
43.00	04300	NURSERY	14,956,201		14,956,201			43.00
44.00	04400	SKILLED NURSING FACILITY	8,428,894		8,428,894			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,309,681	84,115,627	123,425,308	0.161091	0.000000	50.00
51.00	05100	RECOVERY ROOM	6,980,259	7,413,260	14,393,519	0.106667	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	10,046,304	19,768,313	29,814,617	0.023000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,789,006	41,825,730	55,614,736	0.136168	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	499,253	16,723,843	17,223,096	0.215121	0.000000	55.00
57.00	05700	CT SCAN	11,381,936	21,492,727	32,874,663	0.038233	0.000000	57.00
58.00	05800	MRI	5,708,685	15,928,143	21,636,828	0.040985	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,935,493	11,195,515	22,131,008	0.191859	0.000000	59.00
60.00	06000	LABORATORY	47,721,505	37,991,655	85,713,160	0.143927	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,596,399	672,402	4,268,801	0.192589	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	13,370,593	1,041,821	14,412,414	0.168111	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	8,527,619	1,835,836	10,363,455	0.539863	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,831,153	14,652,599	27,483,752	0.041491	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	516,374	1,273,839	1,790,213	0.067351	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,188,091	19,386,931	41,575,022	0.274145	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,678,062	11,607,244	29,285,306	0.406277	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81,484,888	26,005,019	107,489,907	0.155394	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,611,639	124,234	1,735,873	0.462303	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	379,692	379,692	0.304652	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	299,695	3,902,397	4,202,092	0.230175	0.000000	90.00
91.00	09100	EMERGENCY	16,691,969	28,212,657	44,904,626	0.129259	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	2,210	800,095	802,305	0.386147	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,939,050	13,642,608	16,581,658	0.298435	0.000000	92.00
200.00		Subtotal (see instructions)	520,504,705	379,992,187	900,496,892			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	520,504,705	379,992,187	900,496,892			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000		91.01
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: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,906,931	0	8,906,931	53,145	167.60	30.00
31.00	INTENSIVE CARE UNIT	1,106,930		1,106,930	3,334	332.01	31.00
41.00	SUBPROVIDER - IRF	402,501	0	402,501	1,775	226.76	41.00
43.00	NURSERY	467,805		467,805	4,881	95.84	43.00
44.00	SKILLED NURSING FACILITY	1,099,487		1,099,487	7,462	147.34	44.00
200.00	Total (lines 30 through 199)	11,983,654		11,983,654	70,597		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	14,842	2,487,519	30.00
31.00	INTENSIVE CARE UNIT	1,858	616,875	31.00
41.00	SUBPROVIDER - IRF	769	174,378	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	5,588	823,336	44.00
200.00	Total (lines 30 through 199)	23,057	4,102,108	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,132,105	123,425,308	0.025377	14,316,421	363,308	50.00
51.00	05100	RECOVERY ROOM	187,853	14,393,519	0.013051	2,403,605	31,369	51.00
53.00	05300	ANESTHESIOLOGY	92,880	29,814,617	0.003115	3,200,978	9,971	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,319,459	55,614,736	0.023725	5,871,043	139,290	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	484,936	17,223,096	0.028156	304,296	8,568	55.00
57.00	05700	CT SCAN	152,563	32,874,663	0.004641	4,810,847	22,327	57.00
58.00	05800	MRI	98,069	21,636,828	0.004533	1,652,309	7,490	58.00
59.00	05900	CARDIAC CATHETERIZATION	666,680	22,131,008	0.030124	5,137,275	154,755	59.00
60.00	06000	LABORATORY	1,270,634	85,713,160	0.014824	19,352,456	286,881	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	56,188	4,268,801	0.013162	1,224,130	16,112	63.00
65.00	06500	RESPIRATORY THERAPY	290,058	14,412,414	0.020126	6,090,019	122,568	65.00
66.00	06600	PHYSICAL THERAPY	1,008,055	10,363,455	0.097270	2,149,757	209,107	66.00
69.00	06900	ELECTROCARDIOLOGY	91,514	27,483,752	0.003330	5,316,861	17,705	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,056	1,790,213	0.006734	215,034	1,448	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	800,776	41,575,022	0.019261	8,314,501	160,146	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	832,219	29,285,306	0.028418	7,805,570	221,819	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,381,214	107,489,907	0.012850	25,670,251	329,863	73.00
74.00	07400	RENAL DIALYSIS	54,054	1,735,873	0.031139	934,756	29,107	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,978	379,692	0.021012	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	93,410	4,202,092	0.022229	129,483	2,878	90.00
91.00	09100	EMERGENCY	418,367	44,904,626	0.009317	6,850,936	63,830	91.00
91.01	09101	PARTIAL HOSPITALIZATION	22,779	802,305	0.028392	2,210	63	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	770,608	16,581,658	0.046474	1,469,854	68,310	92.00
200.00		Total (lines 50 through 199)	13,244,455	708,102,051		123,222,592	2,266,915	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
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	53,145	0.00	14,842	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,334	0.00	1,858	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	1,775	0.00	769	41.00
43.00	04300	NURSERY		0	4,881	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	7,462	0.00	5,588	44.00
200.00		Total (lines 30 through 199)		0	70,597		23,057	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
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	379,484	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	379,484	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	123,425,308	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,393,519	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	29,814,617	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	55,614,736	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	17,223,096	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	32,874,663	0.000000	57.00
58.00	05800	MRI	0	0	0	21,636,828	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,131,008	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	85,713,160	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,268,801	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,412,414	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,363,455	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	27,483,752	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,790,213	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,575,022	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,285,306	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	379,484	379,484	107,489,907	0.003530	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,735,873	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	379,692	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,202,092	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	44,904,626	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	802,305	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,581,658	0.000000	92.00
200.00		Total (lines 50 through 199)	0	379,484	379,484	708,102,051		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	14,316,421	0	13,643,321	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,403,605	0	1,195,011	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,200,978	0	3,458,350	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,871,043	0	10,039,085	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	304,296	0	4,695,501	0	55.00
57.00	05700	CT SCAN	0.000000	4,810,847	0	6,336,730	0	57.00
58.00	05800	MRI	0.000000	1,652,309	0	3,921,296	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	5,137,275	0	4,876,110	0	59.00
60.00	06000	LABORATORY	0.000000	19,352,456	0	8,174,409	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	1,224,130	0	172,237	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,090,019	0	256,829	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	2,149,757	0	265,598	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,316,861	0	4,519,940	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	215,034	0	254,604	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	8,314,501	0	3,528,857	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	7,805,570	0	3,318,999	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003530	25,670,251	90,616	5,340,941	18,854	73.00
74.00	07400	RENAL DIALYSIS	0.000000	934,756	0	72,193	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	178,292	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	129,483	0	1,190,613	0	90.00
91.00	09100	EMERGENCY	0.000000	6,850,936	0	5,799,174	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	2,210	0	258,230	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,469,854	0	4,356,727	0	92.00
200.00		Total (lines 50 through 199)		123,222,592	90,616	85,853,047	18,854	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.161091	13,643,321	12	1,937	2,197,816	50.00
51.00	05100	RECOVERY ROOM	0.106667	1,195,011	0	0	127,468	51.00
53.00	05300	ANESTHESIOLOGY	0.023000	3,458,350	0	0	79,542	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136168	10,039,085	2	320	1,367,002	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.215121	4,695,501	6	734	1,010,101	55.00
57.00	05700	CT SCAN	0.038233	6,336,730	38	5,994	242,272	57.00
58.00	05800	MRI	0.040985	3,921,296	12	1,763	160,714	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191859	4,876,110	9	1,471	935,526	59.00
60.00	06000	LABORATORY	0.143927	8,174,409	619	0	1,176,518	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.192589	172,237	0	0	33,171	63.00
65.00	06500	RESPIRATORY THERAPY	0.168111	256,829	0	0	43,176	65.00
66.00	06600	PHYSICAL THERAPY	0.539863	265,598	0	0	143,387	66.00
69.00	06900	ELECTROCARDIOLOGY	0.041491	4,519,940	0	43	187,537	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.067351	254,604	0	0	17,148	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.274145	3,528,857	0	0	967,419	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406277	3,318,999	32,588	0	1,348,433	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.155394	5,340,941	170	59,536	829,950	73.00
74.00	07400	RENAL DIALYSIS	0.462303	72,193	0	0	33,375	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.304652	178,292	0	0	54,317	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.230175	1,190,613	18	2,298	274,049	90.00
91.00	09100	EMERGENCY	0.129259	5,799,174	1	103	749,595	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.386147	258,230	0	0	99,715	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298435	4,356,727	1	25	1,300,200	92.00
200.00		Subtotal (see instructions)		85,853,047	33,476	74,224	13,378,431	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		85,853,047	33,476	74,224	13,378,431	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2	312		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	44		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1	158		55.00
57.00	05700	CT SCAN	1	229		57.00
58.00	05800	MRI	0	72		58.00
59.00	05900	CARDIAC CATHETERIZATION	2	282		59.00
60.00	06000	LABORATORY	89	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	2		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	13,240	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26	9,252		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	4	529		90.00
91.00	09100	EMERGENCY	0	13		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7		92.00
200.00		Subtotal (see instructions)	13,365	10,900		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	13,365	10,900		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,132,105	123,425,308	0.025377	16,470	418	50.00
51.00	05100	RECOVERY ROOM	187,853	14,393,519	0.013051	2,045	27	51.00
53.00	05300	ANESTHESIOLOGY	92,880	29,814,617	0.003115	3,797	12	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,319,459	55,614,736	0.023725	24,801	588	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	484,936	17,223,096	0.028156	8	0	55.00
57.00	05700	CT SCAN	152,563	32,874,663	0.004641	30,452	141	57.00
58.00	05800	MRI	98,069	21,636,828	0.004533	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	666,680	22,131,008	0.030124	679	20	59.00
60.00	06000	LABORATORY	1,270,634	85,713,160	0.014824	220,868	3,274	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	56,188	4,268,801	0.013162	4,452	59	63.00
65.00	06500	RESPIRATORY THERAPY	290,058	14,412,414	0.020126	37,772	760	65.00
66.00	06600	PHYSICAL THERAPY	1,008,055	10,363,455	0.097270	1,070,207	104,099	66.00
69.00	06900	ELECTROCARDIOLOGY	91,514	27,483,752	0.003330	4,639	15	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,056	1,790,213	0.006734	329	2	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	800,776	41,575,022	0.019261	26,489	510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	832,219	29,285,306	0.028418	2,800	80	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,381,214	107,489,907	0.012850	413,483	5,313	73.00
74.00	07400	RENAL DIALYSIS	54,054	1,735,873	0.031139	67,808	2,111	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	7,978	379,692	0.021012	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	93,410	4,202,092	0.022229	12	0	90.00
91.00	09100	EMERGENCY	418,367	44,904,626	0.009317	358	3	91.00
91.01	09101	PARTIAL HOSPITALIZATION	22,779	802,305	0.028392	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,581,658	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	12,473,847	708,102,051		1,927,469	117,432	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	379,484	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	379,484	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	123,425,308	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,393,519	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	29,814,617	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	55,614,736	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	17,223,096	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	32,874,663	0.000000	57.00
58.00	05800	MRI	0	0	0	21,636,828	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,131,008	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	85,713,160	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,268,801	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,412,414	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,363,455	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	27,483,752	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,790,213	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,575,022	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,285,306	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	379,484	379,484	107,489,907	0.003530	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,735,873	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	379,692	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,202,092	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	44,904,626	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	802,305	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,581,658	0.000000	92.00
200.00		Total (lines 50 through 199)	0	379,484	379,484	708,102,051		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	16,470	0	456	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	2,045	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,797	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	24,801	0	5,742	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	8	0	237	0	55.00
57.00	05700	CT SCAN	0.000000	30,452	0	1,448	0	57.00
58.00	05800	MRI	0.000000	0	0	470	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	679	0	337	0	59.00
60.00	06000	LABORATORY	0.000000	220,868	0	17	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	4,452	0	3	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	37,772	0	1,186	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,070,207	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,639	0	12	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	329	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	26,489	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,800	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003530	413,483	1,460	6,485	23	73.00
74.00	07400	RENAL DIALYSIS	0.000000	67,808	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	12	0	691	0	90.00
91.00	09100	EMERGENCY	0.000000	358	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	5	0	92.00
200.00		Total (lines 50 through 199)		1,927,469	1,460	17,089	23	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | 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	0.161091	456	0	0	73	50.00
51.00	05100	RECOVERY ROOM	0.106667	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.023000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136168	5,742	0	0	782	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.215121	237	0	0	51	55.00
57.00	05700	CT SCAN	0.038233	1,448	0	0	55	57.00
58.00	05800	MRI	0.040985	470	0	0	19	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191859	337	0	0	65	59.00
60.00	06000	LABORATORY	0.143927	17	0	0	2	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.192589	3	0	0	1	63.00
65.00	06500	RESPIRATORY THERAPY	0.168111	1,186	0	0	199	65.00
66.00	06600	PHYSICAL THERAPY	0.539863	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.041491	12	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.067351	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.274145	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406277	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.155394	6,485	0	0	1,008	73.00
74.00	07400	RENAL DIALYSIS	0.462303	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.304652	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.230175	691	0	0	159	90.00
91.00	09100	EMERGENCY	0.129259	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.386147	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298435	5	0	0	1	92.00
200.00		Subtotal (see instructions)		17,089	0	0	2,415	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		17,089	0	0	2,415	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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	379,484	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	379,484	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | 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	123,425,308	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	14,393,519	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	29,814,617	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	55,614,736	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	17,223,096	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	32,874,663	0.000000	57.00
58.00	05800	MRI	0	0	0	21,636,828	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	22,131,008	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	85,713,160	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	4,268,801	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,412,414	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	10,363,455	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	27,483,752	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,790,213	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	41,575,022	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	29,285,306	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	379,484	379,484	107,489,907	0.003530	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,735,873	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	379,692	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	4,202,092	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	44,904,626	0.000000	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0	0	802,305	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,581,658	0.000000	92.00
200.00		Total (lines 50 through 199)	0	379,484	379,484	708,102,051		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	48	0	0	0	55.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	81,793	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	28,215	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	991,865	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,235,430	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	841,441	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.003530	3,115,923	10,999	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.000000	2,599	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.000000	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		6,297,315	10,999	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | 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	0.161091	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.106667	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.023000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136168	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.215121	0	0	0	0	55.00
57.00	05700	CT SCAN	0.038233	0	0	0	0	57.00
58.00	05800	MRI	0.040985	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191859	0	0	0	0	59.00
60.00	06000	LABORATORY	0.143927	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.192589	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.168111	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.539863	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.041491	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.067351	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.274145	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406277	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.155394	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.462303	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.304652	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.230175	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.129259	0	0	0	0	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.386147	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298435	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | 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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	PARTIAL HOSPITALIZATION	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	53,145	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	53,145	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)	48,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	14,842	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	57,196,971	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)	57,196,971	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)	57,196,971	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)	1,076.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	15,973,554	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)	15,973,554	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,653,167	3,334	2,295.49	1,858	4,265,020	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)	21,405,605	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	41,644,179	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)	3,104,394	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,357,531	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	5,461,925	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	36,182,254	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	4,598	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,076.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,948,552	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	8,906,931	57,196,971	0.155724	4,948,552	770,608	90.00
91.00	Nursing School cost	0	57,196,971	0.000000	4,948,552	0	91.00
92.00	Allied health cost	0	57,196,971	0.000000	4,948,552	0	92.00
93.00	All other Medical Education	0	57,196,971	0.000000	4,948,552	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,775	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,775	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)	1,775	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	769	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,235,070	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)	2,235,070	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)	2,235,070	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)	1,259.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	968,317	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)	968,317	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	728,656	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,696,973	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)	174,378	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	118,892	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	293,270	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,403,703	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	402,501	2,235,070	0.180084	0	0	90.00
91.00	Nursing School cost	0	2,235,070	0.000000	0	0	91.00
92.00	Allied health cost	0	2,235,070	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,235,070	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,462	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,462	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,462	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,588	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,252,699	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)	6,252,699	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)	6,252,699	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,252,699	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	837.94	71.00
72.00	Program routine service cost (line 9 x line 71)	4,682,409	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	4,682,409	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	4,682,409	83.00
84.00	Program inpatient ancillary services (see instructions)	1,566,131	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	6,248,540	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1

Component CCN: 14-5568 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	53,145	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	53,145	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)	48,547	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	918	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	4,881	15.00
16.00	Nursery days (title V or XIX only)	1,424	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)	56,944,332	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)	56,944,332	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)	56,944,332	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)	1,071.49	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	983,628	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)	983,628	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	4,842,659	4,881	992.14	1,424	1,412,807	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	7,653,167	3,334	2,295.49	100	229,549	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,625,984	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	4,598	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,071.49	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,926,711	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	8,906,931	56,944,332	0.156415	4,926,711	770,612	90.00
91.00	Nursing School cost	0	56,944,332	0.000000	4,926,711	0	91.00
92.00	Allied health cost	0	56,944,332	0.000000	4,926,711	0	92.00
93.00	All other Medical Education	0	56,944,332	0.000000	4,926,711	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/29/2018 4:29 pm
	Title XIX	Subprovider - IRF	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,775	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,775	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)	1,775	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	120	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	4,881	15.00
16.00	Nursery days (title V or XIX only)	1,424	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,235,070	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)	2,235,070	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)	2,235,070	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)	1,259.19	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	151,103	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)	151,103	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Subprovider - IRF | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	151,103	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Subprovider - IRF | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	402,501	2,235,070	0.180084	0	0	90.00
91.00	Nursing School cost	0	2,235,070	0.000000	0	0	91.00
92.00	Allied health cost	0	2,235,070	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,235,070	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		43,016,918		30.00
31.00	03100	INTENSIVE CARE UNIT		9,523,558		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.161091	14,316,421	2,306,247	50.00
51.00	05100	RECOVERY ROOM	0.106667	2,403,605	256,385	51.00
53.00	05300	ANESTHESIOLOGY	0.023000	3,200,978	73,622	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136168	5,871,043	799,448	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.215121	304,296	65,460	55.00
57.00	05700	CT SCAN	0.038233	4,810,847	183,933	57.00
58.00	05800	MRI	0.040985	1,652,309	67,720	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191859	5,137,275	985,632	59.00
60.00	06000	LABORATORY	0.143927	19,352,456	2,785,341	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.192589	1,224,130	235,754	63.00
65.00	06500	RESPIRATORY THERAPY	0.168111	6,090,019	1,023,799	65.00
66.00	06600	PHYSICAL THERAPY	0.539863	2,149,757	1,160,574	66.00
69.00	06900	ELECTROCARDIOLOGY	0.041491	5,316,861	220,602	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.067351	215,034	14,483	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.274145	8,314,501	2,279,379	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406277	7,805,570	3,171,224	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.155394	25,670,251	3,989,003	73.00
74.00	07400	RENAL DIALYSIS	0.462303	934,756	432,141	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.304652	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.230175	129,483	29,804	90.00
91.00	09100	EMERGENCY	0.129259	6,850,936	885,545	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.386147	2,210	853	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298435	1,469,854	438,656	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		123,222,592	21,405,605	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)		123,222,592		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,295		30.00
31.00	03100	INTENSIVE CARE UNIT		352		31.00
41.00	04100	SUBPROVIDER - IRF		2,023,568		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.161091	16,470	2,653	50.00
51.00	05100	RECOVERY ROOM	0.106667	2,045	218	51.00
53.00	05300	ANESTHESIOLOGY	0.023000	3,797	87	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136168	24,801	3,377	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.215121	8	2	55.00
57.00	05700	CT SCAN	0.038233	30,452	1,164	57.00
58.00	05800	MRI	0.040985	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191859	679	130	59.00
60.00	06000	LABORATORY	0.143927	220,868	31,789	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.192589	4,452	857	63.00
65.00	06500	RESPIRATORY THERAPY	0.168111	37,772	6,350	65.00
66.00	06600	PHYSICAL THERAPY	0.539863	1,070,207	577,765	66.00
69.00	06900	ELECTROCARDIOLOGY	0.041491	4,639	192	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.067351	329	22	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.274145	26,489	7,262	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406277	2,800	1,138	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.155394	413,483	64,253	73.00
74.00	07400	RENAL DIALYSIS	0.462303	67,808	31,348	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.304652	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.230175	12	3	90.00
91.00	09100	EMERGENCY	0.129259	358	46	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.386147	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298435	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,927,469	728,656	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,927,469		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.161091	0	0	50.00
51.00	05100	RECOVERY ROOM	0.106667	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.023000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136168	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.215121	48	10	55.00
57.00	05700	CT SCAN	0.038233	0	0	57.00
58.00	05800	MRI	0.040985	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.191859	1	0	59.00
60.00	06000	LABORATORY	0.143927	81,793	11,772	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.192589	28,215	5,434	63.00
65.00	06500	RESPIRATORY THERAPY	0.168111	991,865	166,743	65.00
66.00	06600	PHYSICAL THERAPY	0.539863	1,235,430	666,963	66.00
69.00	06900	ELECTROCARDIOLOGY	0.041491	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.067351	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.274145	841,441	230,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406277	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.155394	3,115,923	484,196	73.00
74.00	07400	RENAL DIALYSIS	0.462303	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTER	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.304652	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.230175	0	0	90.00
91.00	09100	EMERGENCY	0.129259	2,599	336	91.00
91.01	09101	PARTIAL HOSPITALIZATION	0.386147	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.298435	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,297,315	1,566,131	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)		6,297,315		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	20,034,210	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6,508,938	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)	849,483	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	7,519,906	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	264.56	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)	139.15	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)	22.76	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.	0.64	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).	-11.52	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)	7.00	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)	111.23	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	110.15	10.00
11.00	FTE count for residents in dental and podiatric programs.	11.13	11.00
12.00	Current year allowable FTE (see instructions)	121.28	12.00
13.00	Total allowable FTE count for the prior year.	120.88	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.	123.53	14.00
15.00	Sum of lines 12 through 14 divided by 3.	121.90	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	121.90	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.460765	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.457065	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.457065	21.00
22.00	IME payment adjustment (see instructions)	5,901,232	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	1,671,871	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)	-1.08	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)	5,901,232	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	1,671,871	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	8.68	30.00
31.00	Percentage of Medicaid patient days (see instructions)	19.65	31.00
32.00	Sum of lines 30 and 31	28.33	32.00
33.00	Allowable disproportionate share percentage (see instructions)	12.59	33.00
34.00	Disproportionate share adjustment (see instructions)	835,446	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,780,995	1,860,774	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,332,086	469,017	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,801,103		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	35,930,412		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	37,602,283	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	2,941,755	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).	4,966,175	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)	90,616	58.00
59.00	Total (sum of amounts on lines 49 through 58)	45,600,829	59.00
60.00	Primary payer payments	19,922	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	45,580,907	61.00
62.00	Deductibles billed to program beneficiaries	2,724,764	62.00
63.00	Coinsurance billed to program beneficiaries	182,924	63.00
64.00	Allowable bad debts (see instructions)	539,986	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	350,991	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	252,554	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	43,024,210	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	156,922	70.93
70.94	HRR adjustment amount (see instructions)	-387,836	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		42,793,296	71.00
71.01	Sequestration adjustment (see instructions)		855,866	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		41,530,837	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)		406,593	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		155,645	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,034,210	0	20,034,210		20,034,210	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,508,938	0		6,508,938	6,508,938	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	849,483	0	645,197	204,286	849,483	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,519,906	0	5,824,882	1,695,025	7,519,907	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.457065	0.457065	0.457065	0.457065		5.00
6.00	IME payment adjustment (see instructions)	22.00	5,901,232	0	4,454,126	1,447,106	5,901,232	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,671,871	0	1,671,871	0	1,671,871	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	5,901,232	0	4,454,126	1,447,106	5,901,232	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,671,871	0	1,671,871	0	1,671,871	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1259	0.1259	0.1259	0.1259		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	835,446	0	630,577	204,869	835,446	11.00
11.01	Uncompensated care payments	36.00	1,801,103	0	2,560,008	0	2,560,008	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	35,930,412	0	27,565,213	8,365,199	35,930,412	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	37,602,283	0	29,237,084	8,365,199	37,602,283	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,941,755	0	2,193,302	748,453	2,941,755	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	31,430,386	9,113,652	40,544,038	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,151,680	0	1,621,560	530,120	2,151,680	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	83,464	0	39,222	44,242	83,464	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.2693	0.2693	0.2693	0.2693		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	579,447	0	436,686	142,761	579,447	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0591	0.0591	0.0591	0.0591		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	127,164	0	95,834	31,330	127,164	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,941,755	0	2,193,302	748,453	2,941,755	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	20,034,210	20,034,210		20,034,210	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	6,508,938		6,508,938	6,508,938	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	849,483	645,197	204,286	849,483	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	7,519,906	5,824,882	1,695,025	7,519,907	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.457065	0.457065	0.457065		5.00
6.00	IME payment adjustment (see instructions)	22.00	5,901,232	4,454,126	1,447,106	5,901,232	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,671,871	1,295,023	376,848	1,671,871	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	5,901,232	4,454,126	1,447,106	5,901,232	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,671,871	1,295,023	376,848	1,671,871	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1259	0.1259	0.1259		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	835,446	630,577	204,869	835,446	11.00
11.01	Uncompensated care payments	36.00	1,801,103	1,332,086	469,017	1,801,103	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	35,930,412	27,096,196	8,834,216	35,930,412	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	37,602,283	28,391,219	9,211,064	37,602,283	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,941,755	2,193,302	748,453	2,941,755	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			30,584,521	9,959,517	40,544,038	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,151,680	1,621,560	530,120	2,151,680	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	83,464	39,222	44,242	83,464	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.2693	0.2693	0.2693		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	579,447	436,686	142,761	579,447	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0591	0.0591	0.0591		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	127,164	95,834	31,330	127,164	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,941,755	2,193,302	748,453	2,941,755	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	156,922	102,878	54,044	156,922	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-387,836	-304,521	-83,315	-387,836	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	24,265	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	13,359,577	2.00
3.00	OPPS payments	11,034,740	3.00
4.00	Outlier payment (see instructions)	151,497	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	18,854	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	24,265	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	107,700	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)	107,700	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)	107,700	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	83,435	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	24,265	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)	11,205,091	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	6,518	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,191,613	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)	9,031,225	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	1,303,267	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)	10,334,492	30.00
31.00	Primary payer payments	8,430	31.00
32.00	Subtotal (line 30 minus line 31)	10,326,062	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)	226,515	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	147,235	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	77,604	36.00
37.00	Subtotal (see instructions)	10,473,297	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	32,800	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	10,473,297	40.00
40.01	Sequestration adjustment (see instructions)	209,466	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	10,350,088	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-86,257	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	2,392	2.00
3.00	OPPS payments	597	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	23	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	620	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)	120	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)	500	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)	500	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	500	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	500	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	500	40.00
40.01	Sequestration adjustment (see instructions)	10	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	468	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	22	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	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)	0	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)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	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)	0	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)		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)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		36,425,312		8,825,742	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		5,105,525		1,524,346	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)		41,530,837		10,350,088	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		406,593		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		86,257	6.02
7.00	Total Medicare program liability (see instructions)		41,937,430		10,263,831	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: 14-0224 | Component CCN: 14-T224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,438,431		468	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	08/02/2016	19,329		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)		-19,329		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,419,102		468	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		65,117		22	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,484,219		490	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: 14-0224 | Component CCN: 14-5568 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,772,237		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,772,237		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		10,788		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,783,025		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: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,285,818	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0000	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	97,079	3.00
4.00	Outlier Payments	133,368	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	4.863014	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,516,265	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,516,265	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	1,516,265	19.00
20.00	Deductibles	5,264	20.00
21.00	Subtotal (line 19 minus line 20)	1,511,001	21.00
22.00	Coinsurance	0	22.00
23.00	Subtotal (line 21 minus line 22)	1,511,001	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,150	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,048	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,150	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,513,049	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	1,460	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,514,509	32.00
32.01	Sequestration adjustment (see instructions)	30,290	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	1,419,102	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	65,117	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	4,467	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	133,368	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224 Component CCN: 14-5568	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VI Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	3,034,118	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	10,999	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,045,117	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	205,296	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	2,839,821	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	2,839,821	15.00
15.01	Sequestration adjustment (see instructions)	56,796	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	2,772,237	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	10,788	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-3 Part VII | Date/Time Prepared: 5/29/2018 4:29 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	2,625,984		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,625,984	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,625,984	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,625,984	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	2,625,984	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0224 Component CCN: 14-T224	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2018 4:29 pm
	Title XIX	Subprovider - IRF	Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	151,103		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	151,103	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	151,103	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	151,103	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	151,103	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-4 | Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			142.44	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			23.61	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.79	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-13.03	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			7.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			111.01	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			110.21	6.00
7.00	Enter the lesser of line 5 or line 6			110.21	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	94.25	14.57	108.82	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	94.25	14.57	108.82	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		11.13		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	94.25	25.70		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	91.54	25.28		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	92.55	27.22		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	92.78	26.07		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	92.78	26.07		17.00
18.00	Per resident amount	134,075.74	129,234.91		18.00
19.00	Approved amount for resident costs	12,439,547	3,369,154	15,808,701	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			15,808,701	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	17,469	4,793		26.00
27.00	Total Inpatient Days (see instructions)	54,427	54,427		27.00
28.00	Ratio of inpatient days to total inpatient days	0.320962	0.088063		28.00
29.00	Program direct GME amount	5,073,992	1,392,162		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		196,712		30.00
31.00	Net Program direct GME amount			6,269,442	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet E-4 Date/Time Prepared: 5/29/2018 4:29 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	1,735,873	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	51,068,678	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	19,922	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	51,048,756	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	13,405,111	42.00
43.00	Primary payer payments (see instructions)	8,430	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	13,396,681	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	64,445,437	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.792124	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.207876	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	6,269,442	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	4,966,175	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	1,303,267	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/29/2018 4:29 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	25,341	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	90,969,900	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-63,437,920	0	0	0	6.00
7.00	Inventory	5,684,137	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	2,642,649	0	0	0	9.00
10.00	Due from other funds	-10,191,643	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,692,464	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	7,327,666	0	0	0	12.00
13.00	Land improvements	2,510,766	0	0	0	13.00
14.00	Accumulated depreciation	-607,648	0	0	0	14.00
15.00	Buildings	100,500,495	0	0	0	15.00
16.00	Accumulated depreciation	-40,952,245	0	0	0	16.00
17.00	Leasehold improvements	22,543,500	0	0	0	17.00
18.00	Accumulated depreciation	-2,442,213	0	0	0	18.00
19.00	Fixed equipment	32,231,265	0	0	0	19.00
20.00	Accumulated depreciation	-19,482,710	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	75,421,592	0	0	0	23.00
24.00	Accumulated depreciation	-36,457,110	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	140,593,358	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,386,020	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,386,020	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	167,671,842	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,694,931	0	0	0	37.00
38.00	Salaries, wages, and fees payable	43,500	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	19,629,802	0	0	0	43.00
44.00	Other current liabilities	103,645,251	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	126,013,484	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	16,913,414	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	16,913,414	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	142,926,898	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	24,744,944				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	24,744,944	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	167,671,842	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/29/2018 4:29 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		31,147,585		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,402,641				2.00
3.00	Total (sum of line 1 and line 2)		24,744,944		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	TRANSFER FROM AFFILIATE	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		24,744,944		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,744,944		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00			0		5.00
6.00	TRANSFER FROM AFFILIATE		0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/29/2018 4:29 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	160,188,951		160,188,951	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	4,662,942		4,662,942	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	8,428,894		8,428,894	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)	173,280,787		173,280,787	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	19,114,054		19,114,054	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)	19,114,054		19,114,054	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	192,394,841		192,394,841	17.00
18.00	Ancillary services	328,109,863	333,434,431	661,544,294	18.00
19.00	Outpatient services	0	46,557,758	46,557,758	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER MISC REVENUES	427,683	17,261,323	17,689,006	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	520,932,387	397,253,512	918,185,899	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		232,816,916		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	RECONCILING ITEM	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)		232,816,916		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0224	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/29/2018 4:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	918,185,899	1.00
2.00	Less contractual allowances and discounts on patients' accounts	700,108,525	2.00
3.00	Net patient revenues (line 1 minus line 2)	218,077,374	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	232,816,916	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-14,739,542	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	86,940	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,191,802	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	1,181	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REVENUE FROM OTHER SOURCES	6,828,892	24.00
24.01	NET ASSETS RELEASED FROM RESTRICTION	228,086	24.01
25.00	Total other income (sum of lines 6-24)	8,336,901	25.00
26.00	Total (line 5 plus line 25)	-6,402,641	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-6,402,641	29.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 14-0224 | Period: From 01/01/2017 To 12/31/2017 | Worksheet L Parts I-III Date/Time Prepared: 5/29/2018 4:29 pm

Title XVIII | Hospital | PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	2,151,680	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	83,464	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)	144.25	3.00
4.00	Number of interns & residents (see instructions)	121.90	4.00
5.00	Indirect medical education percentage (see instructions)	26.93	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)	579,447	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	8.68	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	19.65	8.00
9.00	Sum of lines 7 and 8	28.33	9.00
10.00	Allowable disproportionate share percentage (see instructions)	5.91	10.00
11.00	Disproportionate share adjustment (see instructions)	127,164	11.00
12.00	Total prospective capital payments (see instructions)	2,941,755	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