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: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 5/30/2018 9:10 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2018 Time: 9:10 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ANDERSON HOSPITAL (14-0289) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-12,850	24,535	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	12,798	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-52	24,535	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:08 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 6800 STATE ROUTE 162	PO Box:			1.00
2.00	City: MARYVILLE	State: IL	Zip Code: 62062-1000	County: MADISON	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	ANDERSON HOSPITAL	140289	41180	1	11/22/1976	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	THE REHABILITATION CENTER	14T289	41180	5	01/01/2005	N	P	N	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	ANDERSON HOME HEALTH	147420	41180		05/30/1985	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,722	755	0	0	2,510	210	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.	135	58	0	0	191		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:08 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2018 9:08 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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
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)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:08 am

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		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.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	1,600,000	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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:08 am

		1.00	2.00	
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		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	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)	0.00	169.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 5/30/2018 9:08 am

		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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2018 9:08 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	04/17/2018	Y	04/17/2018
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)	N		N	
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	
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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 9:08 am

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

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	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.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	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.	N	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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	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.	N	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.	N	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.	N	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.	N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		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.	N		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.	BKD, LLP	BKD, LLP	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 5/30/2018 9:08 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BKD, LLP		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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I Date/Time Prepared: 5/30/2018 9:08 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	106	38,690	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)		106	38,690	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	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)		130	47,450	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		154				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 9:08 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,626	1,370	21,952			1.00
2.00	HMO and other (see instructions)	5,164	3,265				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	635	249				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	8,626	1,370	21,952			7.00
8.00	INTENSIVE CARE UNIT	884	147	2,350			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		205	3,292			13.00
14.00	Total (see instructions)	9,510	1,722	27,594	0.00	896.33	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	2,741	135	4,431	0.00	18.21	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,458	0	7,494	0.00	14.29	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	928.83	27.00
28.00	Observation Bed Days		0	3,356			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	210	476			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2018 9:08 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,357	336	8,759	1.00
2.00	HMO and other (see instructions)			1,268	875		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				23		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,357	336	8,759	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	210	10	341	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2018 9:08 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	52,142,039	0	52,142,039	1,932,047.00	26.99	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		148,286	0	148,286	1,050.21	141.20	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,926,831	113	1,926,944	71,746.65	26.86	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		272,267	0	272,267	7,426.50	36.66	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		410,500	0	410,500	2,103.50	195.15	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		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)		10,242,678	0	10,242,678			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		383,865	0	383,865			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part II Date/Time Prepared: 5/30/2018 9:08 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	467,437	0	467,437	13,101.00	35.68	26.00
27.00	Administrative & General	5.00	8,653,493	-399,029	8,254,464	294,403.00	28.04	27.00
28.00	Administrative & General under contract (see inst.)		1,153,983	0	1,153,983	29,763.85	38.77	28.00
29.00	Maintenance & Repairs	6.00	1,093,379	0	1,093,379	36,024.00	30.35	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	58,227	0	58,227	4,219.00	13.80	31.00
32.00	Housekeeping	9.00	1,179,265	0	1,179,265	78,061.00	15.11	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	860,997	-582,138	278,859	20,339.28	13.71	34.00
35.00	Dietary under contract (see instructions)		1,344,961	0	1,344,961	16,403.83	81.99	35.00
36.00	Cafeteria	11.00	0	582,138	582,138	42,459.72	13.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	556,945	0	556,945	11,684.00	47.67	38.00
39.00	Central Services and Supply	14.00	735,369	0	735,369	42,075.00	17.48	39.00
40.00	Pharmacy	15.00	1,561,355	-1,561,355	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,145,280	0	1,145,280	57,697.00	19.85	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part III Date/Time Prepared: 5/30/2018 9:08 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		54,492,697	0	54,492,697	1,977,164.47	27.56	1.00
2.00	Excluded area salaries (see instructions)		1,926,831	113	1,926,944	71,746.65	26.86	2.00
3.00	Subtotal salaries (line 1 minus line 2)		52,565,866	-113	52,565,753	1,905,417.82	27.59	3.00
4.00	Subtotal other wages & related costs (see inst.)		682,767	0	682,767	9,530.00	71.64	4.00
5.00	Subtotal wage-related costs (see inst.)		10,242,678	0	10,242,678	0.00	19.49	5.00
6.00	Total (sum of lines 3 thru 5)		63,491,311	-113	63,491,198	1,914,947.82	33.16	6.00
7.00	Total overhead cost (see instructions)		18,810,691	-1,960,384	16,850,307	646,230.68	26.07	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part IV Date/Time Prepared: 5/30/2018 9:08 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,354,764	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	9,001	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)	4,683,080	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	197,852	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	42,242	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)	59,153	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	8,641	14.00
15.00	'Workers' Compensation Insurance	345,824	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	3,741,421	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	40,835	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))	47,803	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	48,191	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,578,807	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-3 Part V | Date/Time Prepared: 5/30/2018 9:08 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	272,267	10,578,807	1.00
2.00	Hospital	272,267	10,578,807	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			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	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0289 | Component CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-4 | Date/Time Prepared: 5/30/2018 9:08 am

Home Health Agency I | PPS

					1.00		
0.00	County				MADISON		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,056	167	1,429	3,652	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	258.00	5.00	271.00	534.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel			2.70	0.00	2.70	5.00
6.00	Direct Nursing Service			3.50	0.00	3.50	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.10	0.00	4.10	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			1.40	0.00	1.40	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			2.00	0.00	2.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			1.00	0.00	1.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.70	0.00	1.70	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	MANAGER			1.00	0.00	1.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			41180			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,191	207	147	30	1,575	21.00
22.00	Skilled Nursing Visit Charges	188,178	32,706	23,068	4,740	248,692	22.00
23.00	Physical Therapy Visits	1,023	59	17	14	1,113	23.00
24.00	Physical Therapy Visit Charges	161,634	9,322	2,686	2,212	175,854	24.00
25.00	Occupational Therapy Visits	428	25	11	13	477	25.00
26.00	Occupational Therapy Visit Charges	67,624	3,950	1,738	2,054	75,366	26.00
27.00	Speech Pathology Visits	73	28	1	1	103	27.00
28.00	Speech Pathology Visit Charges	11,534	4,424	158	158	16,274	28.00
29.00	Medical Social Service Visits	1	0	0	0	1	29.00
30.00	Medical Social Service Visit Charges	210	0	0	0	210	30.00
31.00	Home Health Aide Visits	303	72	0	0	375	31.00
32.00	Home Health Aide Visit Charges	25,452	6,048	0	0	31,500	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,019	391	176	58	3,644	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	454,632	56,450	27,650	9,164	547,896	35.00
36.00	Total Number of Episodes (standard/non outlier)	228		62	5	295	36.00
37.00	Total Number of Outlier Episodes		12		1	13	37.00
38.00	Total Non-Routine Medical Supply Charges	8,254	2,778	1,394	180	12,606	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet S-10 | Date/Time Prepared: 5/30/2018 9:08 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.217736	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	9,783,588	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	17,380,651	6.00
7.00	Medicaid cost (line 1 times line 6)	3,784,393	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)	0	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)	0	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)	5,484,134	3,528,076	9,012,210	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,194,093	3,528,076	4,722,169	21.00
22.00	Payments received from patients for amounts previously written off as charity care	46,172	274,452	320,624	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,147,921	3,253,624	4,401,545	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)	6,727,346	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	526,347	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	809,765	27.01
28.00	Non-Medicare bad debt expense (see instructions)	5,917,581	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,571,888	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	5,973,433	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,973,433	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		3,159,633	3,159,633	1,438,006	4,597,639	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,313,646	3,313,646	374,855	3,688,501	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	467,437	11,203,075	11,670,512	1,219	11,671,731	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,653,493	20,281,866	28,935,359	-1,144,403	27,790,956	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,093,379	862,266	1,955,645	-9	1,955,636	6.00
7.00	00700	OPERATION OF PLANT	0	2,126,539	2,126,539	36,343	2,162,882	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,227	491,882	550,109	0	550,109	8.00
9.00	00900	HOUSEKEEPING	1,179,265	302,341	1,481,606	-8,528	1,473,078	9.00
10.00	01000	DIETARY	860,997	992,740	1,853,737	-1,253,350	600,387	10.00
11.00	01100	CAFETERIA	0	0	0	1,253,350	1,253,350	11.00
13.00	01300	NURSING ADMINISTRATION	556,945	261,854	818,799	-247,608	571,191	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	735,369	739,912	1,475,281	-541,688	933,593	14.00
15.00	01500	PHARMACY	1,561,355	5,863,265	7,424,620	-1,715,745	5,708,875	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,145,280	501,946	1,647,226	-1,324	1,645,902	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	58,703	-15,318	43,385	-27	43,358	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,430,028	340,733	6,770,761	2,725,751	9,496,512	30.00
31.00	03100	INTENSIVE CARE UNIT	1,921,603	179,861	2,101,464	-13,687	2,087,777	31.00
41.00	04100	SUBPROVIDER - IRF	923,061	637,906	1,560,967	-562	1,560,405	41.00
43.00	04300	NURSERY	0	0	0	506,690	506,690	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,127,158	9,736,230	14,863,388	-7,652,607	7,210,781	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,180,505	478,475	4,658,980	-3,462,695	1,196,285	52.00
53.00	05300	ANESTHESIOLOGY	0	343,871	343,871	-84,151	259,720	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,125,751	1,170,196	3,295,947	95,231	3,391,178	54.00
56.00	05600	RADIOISOTOPE	168,741	372,442	541,183	-273,341	267,842	56.00
57.00	05700	CT SCAN	373,482	862,558	1,236,040	-172,274	1,063,766	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	165,920	514,100	680,020	-53,130	626,890	58.00
59.00	05900	CARDIAC CATHETERIZATION	778,215	1,828,603	2,606,818	-1,571,918	1,034,900	59.00
60.00	06000	LABORATORY	1,418,346	3,356,150	4,774,496	59,275	4,833,771	60.00
65.00	06500	RESPIRATORY THERAPY	1,174,046	385,711	1,559,757	-168,999	1,390,758	65.00
66.00	06600	PHYSICAL THERAPY	1,472,135	280,195	1,752,330	-6,391	1,745,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	814,756	26,696	841,452	134,802	976,254	67.00
68.00	06800	SPEECH PATHOLOGY	696,958	29,061	726,019	81,528	807,547	68.00
68.01	03040	AUDIOLOGY	140,742	171,390	312,132	-147,031	165,101	68.01
69.00	06900	ELECTROCARDIOLOGY	395,785	135,255	531,040	-9,218	521,822	69.00
69.01	03160	CARDIOPULMONARY	515,884	83,123	599,007	-56,820	542,187	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	49,097	7,272	56,369	-5,705	50,664	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,549,286	11,549,286	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,555,898	1,555,898	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	247,608	247,608	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	687,090	4,394,784	5,081,874	-95,806	4,986,068	90.00
91.00	09100	EMERGENCY	5,267,219	778,590	6,045,809	-320,159	5,725,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	945,067	92,377	1,037,444	-9,193	1,028,251	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,043,473	1,043,473	-1,043,473	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,142,039	77,334,699	129,476,738	0	129,476,738	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	52,142,039	77,334,699	129,476,738	0	129,476,738	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-751,963	3,845,676		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-291,510	3,396,991		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-61,797	11,609,934		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,882,433	17,908,523		5.00
6.00	00600	MAINTENANCE & REPAIRS	-21,596	1,934,040		6.00
7.00	00700	OPERATION OF PLANT	-22,128	2,140,754		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	550,109		8.00
9.00	00900	HOUSEKEEPING	0	1,473,078		9.00
10.00	01000	DIETARY	0	600,387		10.00
11.00	01100	CAFETERIA	0	1,253,350		11.00
13.00	01300	NURSING ADMINISTRATION	-26,263	544,928		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	933,593		14.00
15.00	01500	PHARMACY	0	5,708,875		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-105,461	1,540,441		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	43,358		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	9,496,512		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,087,777		31.00
41.00	04100	SUBPROVIDER - IRF	0	1,560,405		41.00
43.00	04300	NURSERY	0	506,690		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	7,210,781		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-4,376	1,191,909		52.00
53.00	05300	ANESTHESIOLOGY	-72,795	186,925		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-65,227	3,325,951		54.00
56.00	05600	RADIOISOTOPE	0	267,842		56.00
57.00	05700	CT SCAN	0	1,063,766		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	626,890		58.00
59.00	05900	CARDIAC CATHETERIZATION	-10,666	1,024,234		59.00
60.00	06000	LABORATORY	0	4,833,771		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,390,758		65.00
66.00	06600	PHYSICAL THERAPY	0	1,745,939		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	976,254		67.00
68.00	06800	SPEECH PATHOLOGY	0	807,547		68.00
68.01	03040	AUDIOLOGY	0	165,101		68.01
69.00	06900	ELECTROCARDIOLOGY	0	521,822		69.00
69.01	03160	CARDIOPULMONARY	-41,552	500,635		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	50,664		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,549,286		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,555,898		73.00
74.00	07400	RENAL DIALYSIS	0	247,608		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	4,986,068		90.00
91.00	09100	EMERGENCY	0	5,725,650		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	1,028,251		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,357,767	118,118,971		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,357,767	118,118,971		200.00

RECLASSIFICATIONS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 9:08 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - TO RECLASS INTEREST EXPENSE TO CAPTL					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	751,963		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	291,510		2.00
	0		0	1,043,473		
	B - TO RECLASS EXPENSES FOR CAFETERIA					
1.00	CAFETERIA	11.00	582,138	671,212		1.00
	0		582,138	671,212		
	C - TO RECLASS SAL EXP FROM LDR					
1.00	ADULTS & PEDIATRICS	30.00	2,582,465	295,573		1.00
2.00	NURSERY	43.00	475,460	54,418		2.00
	0		3,057,925	349,991		
	D - TO RECLASS EXP FOR UTIL REV					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,324		1.00
	0		0	1,324		
	E - TO RECLASS ELECTRICITY EXP					
1.00	OPERATION OF PLANT	7.00	0	72,927		1.00
2.00		0.00	0	0		2.00
	0		0	72,927		
	F - TO RECLASS TELEPHONE EXP					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	27,402		1.00
2.00		0.00	0	0		2.00
4.00		0.00	0	0		4.00
	0		0	27,402		
	G - TO RECLASS RENAL DIALYSIS EXP					
1.00	RENAL DIALYSIS	74.00	0	247,608		1.00
	0		0	247,608		
	H - INSURANCE EXPENSE					
1.00	OTHER CAP REL COSTS	3.00	0	135,278		1.00
	0		0	135,278		
	I - TO RECLASS EXEC BENEFITS TO EB					
1.00		0.00	0	0		1.00
	0		0	0		
	J - TO RECLASS MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	11,549,286		1.00
2.00	LABORATORY	60.00	0	59,275		2.00
3.00		0.00	0	0		3.00
5.00		0.00	0	0		5.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
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
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
	0		0	11,608,561		
	K - TO RECLASS REAL ESTATE TAXES					
1.00	OTHER CAP REL COSTS	3.00	0	188,215		1.00
	0		0	188,215		
	L - TO RECLASS PHYSICIAN OFFICE LEASE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	445,895		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	445,895		

RECLASSIFICATIONS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 9:08 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	M - TO RECLASS PROF RENUMERATION					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	200,000		1.00
2.00	ANESTHESIOLOGY	53.00	0	175,000		2.00
	0		0	375,000		
	N - TO RECLASS PENSION AUDIT COSTS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,820		1.00
	0		0	1,820		
	O - TO RECLASS REHAB ADMIN EXP					
1.00	SPEECH PATHOLOGY	68.00	73,108	8,420		1.00
2.00	AUDIOLOGY	68.01	14,139	1,629		2.00
3.00	OCCUPATIONAL THERAPY	67.00	120,907	13,926		3.00
4.00	PHYSICAL THERAPY	66.00	190,875	21,984		4.00
	0		399,029	45,959		
	P - TO RECLASS PHARMACISTS SALARIES					
1.00	ADULTS & PEDIATRICS	30.00	3,879	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	608	0		2.00
3.00	SUBPROVIDER - IRF	41.00	113	0		3.00
4.00	NURSERY	43.00	29	0		4.00
5.00	OPERATING ROOM	50.00	328	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	68	0		6.00
7.00	CARDIAC CATHETERIZATION	59.00	133	0		7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	1,555,898	0		8.00
9.00	EMERGENCY	91.00	299	0		9.00
	0		1,561,355	0		
	Q - TO RECLASS CABLE TB EXPS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,128		1.00
2.00		0.00	0	0		2.00
	0		0	22,128		
500.00	Grand Total: Increases		5,600,447	15,236,793		500.00

RECLASSIFICATIONS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 9:08 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE TO CAPTL						
1.00	INTEREST EXPENSE	113.00	0	1,043,473	11		1.00
2.00		0.00	0	0	11		2.00
	0		0	1,043,473			
	B - TO RECLASS EXPENSES FOR CAFETERIA						
1.00	DIETARY	10.00	582,138	671,212	0		1.00
	0		582,138	671,212			
	C - TO RECLASS SAL EXP FROM LDR						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	3,057,925	349,991	0		1.00
2.00		0.00	0	0	0		2.00
	0		3,057,925	349,991			
	D - TO RECLASS EXP FOR UTIL REV						
1.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,324	0		1.00
	0		0	1,324			
	E - TO RECLASS ELECTRICITY EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	893	0		1.00
2.00	CLINIC	90.00	0	72,034	0		2.00
	0		0	72,927			
	F - TO RECLASS TELEPHONE EXP						
1.00	OPERATION OF PLANT	7.00	0	18,341	0		1.00
2.00	CLINIC	90.00	0	6,337	0		2.00
4.00	HOME HEALTH AGENCY	101.00	0	2,724	0		4.00
	0		0	27,402			
	G - TO RECLASS RENAL DIALYSIS EXP						
1.00	NURSING ADMINISTRATION	13.00	0	247,608	0		1.00
	0		0	247,608			
	H - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	135,278	12		1.00
	0		0	135,278			
	I - TO RECLASS EXEC BENEFITS TO EB						
1.00		0.00	0	0	0		1.00
	0		0	0			
	J - TO RECLASS MED SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	601	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	798	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	9	0		3.00
5.00	HOUSEKEEPING	9.00	0	8,528	0		5.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	541,688	0		8.00
9.00	PHARMACY	15.00	0	154,390	0		9.00
12.00	PARAMEDICAL EDUCATION PRGM	23.00	0	27	0		12.00
13.00	ADULTS & PEDIATRICS	30.00	0	156,166	0		13.00
14.00	INTENSIVE CARE UNIT	31.00	0	14,295	0		14.00
15.00	SUBPROVIDER - IRF	41.00	0	675	0		15.00
16.00	NURSERY	43.00	0	23,217	0		16.00
17.00	OPERATING ROOM	50.00	0	7,652,935	0		17.00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	0	54,847	0		18.00
19.00	ANESTHESIOLOGY	53.00	0	259,151	0		19.00
20.00	RADIOLOGY-DIAGNOSTIC	54.00	0	104,769	0		20.00
21.00	RADIOISOTOPE	56.00	0	273,341	0		21.00
22.00	CT SCAN	57.00	0	172,274	0		22.00
23.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	53,130	0		23.00
24.00	CARDIAC CATHETERIZATION	59.00	0	1,572,051	0		24.00
25.00	RESPIRATORY THERAPY	65.00	0	168,999	0		25.00
26.00	PHYSICAL THERAPY	66.00	0	2,768	0		26.00
27.00	OCCUPATIONAL THERAPY	67.00	0	31	0		27.00
29.00	AUDIOLOGY	68.01	0	162,799	0		29.00
30.00	ELECTROCARDIOLOGY	69.00	0	9,218	0		30.00
31.00	CARDIOPULMONARY	69.01	0	56,820	0		31.00
32.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,705	0		32.00
33.00	CLINIC	90.00	0	13,550	0		33.00
34.00	EMERGENCY	91.00	0	139,310	0		34.00
35.00	HOME HEALTH AGENCY	101.00	0	6,469	0		35.00
	0		0	11,608,561			
	K - TO RECLASS REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	188,215	0		1.00
	0		0	188,215			
	L - TO RECLASS PHYSICIAN OFFICE LEASE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	48,265	10		1.00
2.00	PHYSICAL THERAPY	66.00	0	216,482	0		2.00
3.00	EMERGENCY	91.00	0	181,148	0		3.00
	0		0	445,895			

RECLASSIFICATIONS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-6 | Date/Time Prepared: 5/30/2018 9:08 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	M - TO RECLASS PROF RENUMERATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	375,000	0		1.00
2.00		0.00	0	0	0		2.00
	0		0	375,000			
	N - TO RECLASS PENSION AUDIT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,820	0		1.00
	0		0	1,820			
	O - TO RECLASS REHAB ADMIN EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	399,029	45,959	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	0		399,029	45,959			
	P - TO RECLASS PHARMACISTS SALARIES						
1.00	PHARMACY	15.00	1,561,355	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	0		1,561,355	0			
	Q - TO RECLASS CABLE TB EXPS						
1.00	CLINIC	90.00	0	3,885	0		1.00
2.00	OPERATION OF PLANT	7.00	0	18,243	0		2.00
	0		0	22,128			
500.00	Grand Total: Decreases		5,600,447	15,236,793			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2018 9:08 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	963,454	0	0	0	0	1.00
2.00	Land Improvements	3,146,603	27,686	0	27,686	56,074	2.00
3.00	Buildings and Fixtures	105,944,132	3,747,082	0	3,747,082	958,281	3.00
4.00	Building Improvements	24,000	0	0	0	0	4.00
5.00	Fixed Equipment	5,236,053	209,895	0	209,895	74,575	5.00
6.00	Movable Equipment	41,004,262	3,438,831	0	3,438,831	3,568,291	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	156,318,504	7,423,494	0	7,423,494	4,657,221	8.00
9.00	Reconciling Items	867,979	341,937	0	341,937	775,630	9.00
10.00	Total (line 8 minus line 9)	155,450,525	7,081,557	0	7,081,557	3,881,591	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	963,454	0	1.00
2.00	Land Improvements	3,118,215	0	2.00
3.00	Buildings and Fixtures	108,732,933	0	3.00
4.00	Building Improvements	24,000	0	4.00
5.00	Fixed Equipment	5,371,373	0	5.00
6.00	Movable Equipment	40,874,802	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	159,084,777	0	8.00
9.00	Reconciling Items	434,286	0	9.00
10.00	Total (line 8 minus line 9)	158,650,491	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2018 9:08 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	3,159,633	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,266,272	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,425,905	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	3,159,633		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	47,374	3,313,646		2.00
3.00	Total (sum of lines 1-2)	47,374	6,473,279		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-7 Part III Date/Time Prepared: 5/30/2018 9:08 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	117,775,689	0	117,775,689	0.742359	100,425	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	40,874,802	0	40,874,802	0.257641	34,853	2.00
3.00	Total (sum of lines 1-2)	158,650,491	0	158,650,491	1.000000	135,278	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	139,723	0	240,148	3,159,633	445,895	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,492	0	83,345	3,266,272	0	2.00
3.00	Total (sum of lines 1-2)	188,215	0	323,493	6,425,905	445,895	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	100,425	139,723	0	3,845,676	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	34,853	48,492	47,374	3,396,991	2.00
3.00	Total (sum of lines 1-2)	0	135,278	188,215	47,374	7,242,667	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 9:08 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-751,963	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-291,510	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-5	ADMINISTRATIVE & GENERAL	5.00	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)	A	-27,591	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-22,128	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,339,551			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	-148,286			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-104,435	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing 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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8 | Date/Time Prepared: 5/30/2018 9:08 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER MISC INCOME	B	-421,222	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	OTHER REVENUE CR CARD SHARING REV	B	-47,023	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MANAGEMENT FEES	B	-163,200	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	EDUCATION CLASSES - VARIOUS	B	-332	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	OB LACTATION REVENUE	B	-4,376	DELIVERY ROOM & LABOR ROOM	52.00	0	33.04
33.05	AH OTHER REVENUE HEALTH MGM	B	-41,464	CARDIOPULMONARY	69.01	0	33.05
33.06	FINANCIAL SERVICE DONATION HMAP	A	-12,138	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	PHYSICIAN RECRUITMENT	A	-173,620	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	LOBBYING PORTION OF DUES	A	-38,358	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ALCOHOL EXPENSE	A	-4,300	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.10	ALCOHOL EXPENSE	A	-1,026	MEDICAL RECORDS & LIBRARY	16.00	0	33.10
33.11	PROMOTIONAL ITEMS	A	-14,742	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	PUBLICITY SALARIES	A	-75,336	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PUBLICITY EXPENSES	A	-261,602	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	PUBLICITY BENEFITS	A	-15,369	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	DONATION EXPENSE	A	-3,740	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.15
33.16	DONATION EXPENSE	A	-16,831	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	PROVIDER TAX OFFSET	A	-6,429,000	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18	SELF-INSURANCE ACCRUAL NOT FUNDED	A	89,874	ADMINISTRATIVE & GENERAL	5.00	0	33.18
33.19	ADVERTISING EXPENSE	A	-36,991	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.20	OTHER REVENUE REBATE INCOME	B	-1,502	ADMINISTRATIVE & GENERAL	5.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,357,767				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: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/30/2018 9:08 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY- STAUNTON	0	1,397	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY- STAUNTON	0	98,942	2.00
3.00	6.00	MAINTENANCE & REPAIRS	RELATED PARTY- STAUNTON	0	21,596	3.00
4.00	13.00	NURSING ADMINISTRATION	RELATED PARTY- STAUNTON	0	26,263	4.00
4.01	69.01	CARDIOPULMONARY	RELATED PARTY- STAUNTON	0	88	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			0	148,286	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	C		0.00	SW IL HLTH FAC	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: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/30/2018 9:08 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,397	0		1.00
2.00	-98,942	0		2.00
3.00	-21,596	0		3.00
4.00	-26,263	0		4.00
4.01	-88	0		4.01
5.00	-148,286			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			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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2018 9:08 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,197,371	2,186,871	10,500	211,500	64	1.00
2.00	53.00	ANESTHESIOLOGY	175,000	0	175,000	239,400	888	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	200,000	0	200,000	271,900	1,031	3.00
4.00	59.00	CARDIAC CATHETERIZATION	25,000	0	25,000	246,400	121	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,597,371	2,186,871	410,500		2,104	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	6,508	325	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	102,205	5,110	0	0	0	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	134,773	6,739	0	0	0	3.00
4.00	59.00	CARDIAC CATHETERIZATION	14,334	717	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			257,820	12,891	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	6,508	3,992	2,190,863		1.00
2.00	53.00	ANESTHESIOLOGY	0	102,205	72,795	72,795		2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC	0	134,773	65,227	65,227		3.00
4.00	59.00	CARDIAC CATHETERIZATION	0	14,334	10,666	10,666		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	257,820	152,680	2,339,551		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,845,676	3,845,676				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,396,991		3,396,991			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	11,609,934	10,672	26,031	11,646,637		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,908,523	309,101	968,195	1,860,424	21,046,243	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,934,040	24,755	414,096	246,430	2,619,321	6.00
7.00	00700	OPERATION OF PLANT	2,140,754	308,896	0	0	2,449,650	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	550,109	3,660	0	13,123	566,892	8.00
9.00	00900	HOUSEKEEPING	1,473,078	25,345	5,778	265,787	1,769,988	9.00
10.00	01000	DIETARY	600,387	88,220	8,853	62,850	760,310	10.00
11.00	01100	CAFETERIA	1,253,350	0	4,241	131,205	1,388,796	11.00
13.00	01300	NURSING ADMINISTRATION	544,928	23,738	0	125,526	694,192	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	933,593	91,863	60,703	165,740	1,251,899	14.00
15.00	01500	PHARMACY	5,708,875	21,104	96,952	0	5,826,931	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,540,441	75,505	12,481	258,128	1,886,555	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	43,358	0	0	13,231	56,589	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,496,512	337,259	142,434	2,032,154	12,008,359	30.00
31.00	03100	INTENSIVE CARE UNIT	2,087,777	78,695	36,770	433,236	2,636,478	31.00
41.00	04100	SUBPROVIDER - IRF	1,560,405	60,584	1,915	208,069	1,830,973	41.00
43.00	04300	NURSERY	506,690	8,739	13,958	107,168	636,555	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,210,781	268,544	414,368	1,155,653	9,049,346	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,191,909	263,567	32,973	253,027	1,741,476	52.00
53.00	05300	ANESTHESIOLOGY	186,925	0	22,033	0	208,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,325,951	59,198	195,065	479,110	4,059,324	54.00
56.00	05600	RADIOISOTOPE	267,842	7,277	6,618	38,032	319,769	56.00
57.00	05700	CT SCAN	1,063,766	91,624	127,349	84,177	1,366,916	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	626,890	20,026	19,315	37,396	703,627	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,024,234	0	223,630	175,427	1,423,291	59.00
60.00	06000	LABORATORY	4,833,771	78,173	203,414	319,672	5,435,030	60.00
65.00	06500	RESPIRATORY THERAPY	1,390,758	51,391	60,894	264,611	1,767,654	65.00
66.00	06600	PHYSICAL THERAPY	1,745,939	244,729	11,351	374,816	2,376,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	976,254	165,299	1,503	210,883	1,353,939	67.00
68.00	06800	SPEECH PATHOLOGY	807,547	61,259	0	173,561	1,042,367	68.00
68.01	03040	AUDIOLOGY	165,101	3,942	3,704	34,908	207,655	68.01
69.00	06900	ELECTROCARDIOLOGY	521,822	0	41,391	89,204	652,417	69.00
69.01	03160	CARDIOPULMONARY	500,635	41,412	16,354	116,272	674,673	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	50,664	0	5,378	11,066	67,108	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,549,286	0	0	0	11,549,286	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,555,898	0	0	350,675	1,906,573	73.00
74.00	07400	RENAL DIALYSIS	247,608	0	0	0	247,608	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,986,068	92,513	140,824	154,859	5,374,264	90.00
91.00	09100	EMERGENCY	5,725,650	251,305	78,223	1,187,214	7,242,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,028,251	15,802	197	213,003	1,257,253	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118,118,971	3,184,197	3,396,991	11,646,637	117,457,492	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,162	0	0	18,162	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	382,692	0	0	382,692	192.00
193.00	19300	NONPAID WORKERS	0	260,625	0	0	260,625	193.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	118,118,971	3,845,676	3,396,991	11,646,637	118,118,971	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,046,243					5.00
6.00	00600	MAINTENANCE & REPAIRS	567,892	3,187,213				6.00
7.00	00700	OPERATION OF PLANT	531,106	281,198	3,261,954			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	122,907	3,332	3,740	696,871		8.00
9.00	00900	HOUSEKEEPING	383,749	23,073	25,899	0	2,202,709	9.00
10.00	01000	DIETARY	164,842	80,310	90,147	0	0	10.00
11.00	01100	CAFETERIA	301,103	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	150,507	21,609	24,256	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	271,423	83,626	93,869	13,014	31,473	14.00
15.00	01500	PHARMACY	1,263,331	19,212	21,565	0	24,116	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	409,022	68,735	77,154	0	23,707	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	12,269	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,603,523	307,018	344,623	224,077	849,775	30.00
31.00	03100	INTENSIVE CARE UNIT	571,612	71,638	80,413	36,089	290,002	31.00
41.00	04100	SUBPROVIDER - IRF	396,971	55,151	61,907	0	184,138	41.00
43.00	04300	NURSERY	138,011	7,955	8,930	0	33,721	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,961,980	244,464	274,407	118,843	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	377,568	239,934	269,322	78,769	79,705	52.00
53.00	05300	ANESTHESIOLOGY	45,304	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	880,098	53,890	60,491	19,243	50,888	54.00
56.00	05600	RADIOISOTOPE	69,329	6,624	7,436	2,365	6,335	56.00
57.00	05700	CT SCAN	296,360	83,408	93,624	29,781	78,683	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	152,553	18,231	20,464	6,510	17,167	58.00
59.00	05900	CARDIAC CATHETERIZATION	308,582	0	0	7,681	0	59.00
60.00	06000	LABORATORY	1,178,363	71,164	79,880	0	39,444	60.00
65.00	06500	RESPIRATORY THERAPY	383,243	46,783	52,514	0	97,689	65.00
66.00	06600	PHYSICAL THERAPY	515,319	222,785	250,073	5,023	100,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	293,546	150,477	168,908	43,868	3,270	67.00
68.00	06800	SPEECH PATHOLOGY	225,995	55,766	62,597	1,924	2,044	68.00
68.01	03040	AUDIOLOGY	45,021	3,589	4,028	373	409	68.01
69.00	06900	ELECTROCARDIOLOGY	141,450	0	0	3,161	0	69.00
69.01	03160	CARDIOPULMONARY	146,275	37,699	42,317	0	13,284	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	14,550	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,503,989	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	413,362	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	53,684	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1,165,189	84,218	94,533	0	0	90.00
91.00	09100	EMERGENCY	1,570,216	228,771	256,792	106,150	276,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	272,584	14,385	16,147	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,902,828	2,585,045	2,586,036	696,871	2,202,709	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,938	16,534	18,559	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82,971	348,378	391,043	0	0	192.00
193.00	19300	NONPAID WORKERS	56,506	237,256	266,316	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	21,046,243	3,187,213	3,261,954	696,871	2,202,709	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,095,609					10.00
11.00	01100	CAFETERIA	0	1,689,899				11.00
13.00	01300	NURSING ADMINISTRATION	0	124,497	1,015,061			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	76,774	0	1,822,078		14.00
15.00	01500	PHARMACY	0	46,389	0	1,923	7,203,467	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	86,226	0	7	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	37,691	0	1	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	802,250	514,456	406,962	35,363	17,894	30.00
31.00	03100	INTENSIVE CARE UNIT	101,666	80,717	75,241	14,071	2,804	31.00
41.00	04100	SUBPROVIDER - IRF	191,693	70,685	0	2,043	521	41.00
43.00	04300	NURSERY	0	13,105	18,159	2,196	132	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	61,292	216,688	76,503	1,512	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	30,907	42,834	5,187	311	52.00
53.00	05300	ANESTHESIOLOGY	0	20,875	0	5,409	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,617	0	3,047	0	54.00
56.00	05600	RADIOISOTOPE	0	3,769	0	254	0	56.00
57.00	05700	CT SCAN	0	47,375	0	6,234	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	10,380	0	166	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	25,457	1,370	614	59.00
60.00	06000	LABORATORY	0	69,816	0	187,588	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	68,946	0	8,767	0	65.00
66.00	06600	PHYSICAL THERAPY	0	29,631	0	816	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,788	0	367	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,365	0	24	0	68.00
68.01	03040	AUDIOLOGY	0	2,203	0	326	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	23,542	0	635	0	69.00
69.01	03160	CARDIOPULMONARY	0	32,936	21,460	851	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	21	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,444,181	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,178,299	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	1,229	0	90.00
91.00	09100	EMERGENCY	0	145,198	208,260	23,039	1,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	460	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,095,609	1,658,180	1,015,061	1,822,078	7,203,467	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	31,719	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,095,609	1,689,899	1,015,061	1,822,078	7,203,467	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,551,406					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	106,550			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	177,591	0	0	18,291,891	0	30.00
31.00	03100	INTENSIVE CARE UNIT	23,083	0	0	3,983,814	0	31.00
41.00	04100	SUBPROVIDER - IRF	29,407	0	0	2,823,489	0	41.00
43.00	04300	NURSERY	21,934	0	0	880,698	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	355,490	0	0	12,360,525	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51,783	0	0	2,917,796	0	52.00
53.00	05300	ANESTHESIOLOGY	55,453	0	0	335,999	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	169,675	0	0	5,327,273	0	54.00
56.00	05600	RADIOISOTOPE	20,872	0	0	436,753	0	56.00
57.00	05700	CT SCAN	262,583	0	0	2,264,964	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,399	0	0	986,497	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	65,137	0	0	1,832,132	0	59.00
60.00	06000	LABORATORY	347,752	0	0	7,409,037	0	60.00
65.00	06500	RESPIRATORY THERAPY	69,913	0	0	2,495,509	0	65.00
66.00	06600	PHYSICAL THERAPY	60,715	0	0	3,561,747	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,993	0	0	2,074,156	0	67.00
68.00	06800	SPEECH PATHOLOGY	15,212	0	0	1,417,294	0	68.00
68.01	03040	AUDIOLOGY	4,997	0	0	268,601	0	68.01
69.00	06900	ELECTROCARDIOLOGY	62,926	0	0	884,131	0	69.00
69.01	03160	CARDIOPULMONARY	9,729	0	0	979,224	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,677	0	0	88,356	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,655	0	0	15,627,111	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	175,203	0	0	9,673,437	0	73.00
74.00	07400	RENAL DIALYSIS	6,500	0	0	307,792	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	37,499	0	0	6,756,932	0	90.00
91.00	09100	EMERGENCY	287,656	0	106,550	10,452,713	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,572	0	0	1,566,401	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,551,406	0	106,550	116,004,272	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	57,193	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,236,803	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	820,703	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,551,406	0	106,550	118,118,971	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part I | Date/Time Prepared: 5/30/2018 9:08 am

		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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
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
23.00	02300	PARAMEDICAL EDUCATION PRGM			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	18,291,891		30.00
31.00	03100	INTENSIVE CARE UNIT	3,983,814		31.00
41.00	04100	SUBPROVIDER - IRF	2,823,489		41.00
43.00	04300	NURSERY	880,698		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	12,360,525		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,917,796		52.00
53.00	05300	ANESTHESIOLOGY	335,999		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,327,273		54.00
56.00	05600	RADIOISOTOPE	436,753		56.00
57.00	05700	CT SCAN	2,264,964		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	986,497		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,832,132		59.00
60.00	06000	LABORATORY	7,409,037		60.00
65.00	06500	RESPIRATORY THERAPY	2,495,509		65.00
66.00	06600	PHYSICAL THERAPY	3,561,747		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,074,156		67.00
68.00	06800	SPEECH PATHOLOGY	1,417,294		68.00
68.01	03040	AUDIOLOGY	268,601		68.01
69.00	06900	ELECTROCARDIOLOGY	884,131		69.00
69.01	03160	CARDIOPULMONARY	979,224		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	88,356		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,627,111		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,673,437		73.00
74.00	07400	RENAL DIALYSIS	307,792		74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	6,756,932		90.00
91.00	09100	EMERGENCY	10,452,713		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	1,566,401		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116,004,272		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	57,193		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,236,803		192.00
193.00	19300	NONPAID WORKERS	820,703		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	118,118,971		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,672	26,031	36,703	36,703	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	90,567	309,101	968,195	1,367,863	5,861	5.00
6.00	00600	MAINTENANCE & REPAIRS	7	24,755	414,096	438,858	776	6.00
7.00	00700	OPERATION OF PLANT	0	308,896	0	308,896	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,660	0	3,660	41	8.00
9.00	00900	HOUSEKEEPING	0	25,345	5,778	31,123	837	9.00
10.00	01000	DIETARY	185	88,220	8,853	97,258	198	10.00
11.00	01100	CAFETERIA	0	0	4,241	4,241	413	11.00
13.00	01300	NURSING ADMINISTRATION	0	23,738	0	23,738	395	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	53,952	91,863	60,703	206,518	522	14.00
15.00	01500	PHARMACY	261,419	21,104	96,952	379,475	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	75,505	12,481	87,986	813	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	0	42	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	337,259	142,434	479,693	6,415	30.00
31.00	03100	INTENSIVE CARE UNIT	0	78,695	36,770	115,465	1,365	31.00
41.00	04100	SUBPROVIDER - IRF	0	60,584	1,915	62,499	655	41.00
43.00	04300	NURSERY	0	8,739	13,958	22,697	338	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	158,377	268,544	414,368	841,289	3,641	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	660	263,567	32,973	297,200	797	52.00
53.00	05300	ANESTHESIOLOGY	13,545	0	22,033	35,578	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	282,936	59,198	195,065	537,199	1,509	54.00
56.00	05600	RADIOISOTOPE	0	7,277	6,618	13,895	120	56.00
57.00	05700	CT SCAN	275,439	91,624	127,349	494,412	265	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	264,087	20,026	19,315	303,428	118	58.00
59.00	05900	CARDIAC CATHETERIZATION	165,283	0	223,630	388,913	553	59.00
60.00	06000	LABORATORY	14,562	78,173	203,414	296,149	1,007	60.00
65.00	06500	RESPIRATORY THERAPY	25,101	51,391	60,894	137,386	834	65.00
66.00	06600	PHYSICAL THERAPY	10,037	244,729	11,351	266,117	1,181	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,454	165,299	1,503	172,256	664	67.00
68.00	06800	SPEECH PATHOLOGY	3,298	61,259	0	64,557	547	68.00
68.01	03040	AUDIOLOGY	639	3,942	3,704	8,285	110	68.01
69.00	06900	ELECTROCARDIOLOGY	25,920	0	41,391	67,311	281	69.00
69.01	03160	CARDIOPULMONARY	0	41,412	16,354	57,766	366	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	5,378	5,378	35	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,105	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	544,589	92,513	140,824	777,926	488	90.00
91.00	09100	EMERGENCY	3,751	251,305	78,223	333,279	3,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	15,802	197	15,999	671	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,199,808	3,184,197	3,396,991	8,780,996	36,703	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18,162	0	18,162	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	382,692	0	382,692	0	192.00
193.00	19300	NONPAID WORKERS	0	260,625	0	260,625	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,199,808	3,845,676	3,396,991	9,442,475	36,703	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,373,724					5.00
6.00	00600	MAINTENANCE & REPAIRS	37,066	476,700				6.00
7.00	00700	OPERATION OF PLANT	34,665	42,058	385,619			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,022	498	442	12,663		8.00
9.00	00900	HOUSEKEEPING	25,047	3,451	3,062	0	63,520	9.00
10.00	01000	DIETARY	10,759	12,012	10,657	0	0	10.00
11.00	01100	CAFETERIA	19,653	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,824	3,232	2,867	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,716	12,508	11,097	236	908	14.00
15.00	01500	PHARMACY	82,457	2,873	2,549	0	695	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,697	10,280	9,121	0	684	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	801	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	169,977	45,920	40,740	4,072	24,506	30.00
31.00	03100	INTENSIVE CARE UNIT	37,309	10,715	9,506	656	8,363	31.00
41.00	04100	SUBPROVIDER - IRF	25,910	8,249	7,318	0	5,310	41.00
43.00	04300	NURSERY	9,008	1,190	1,056	0	972	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	128,057	36,564	32,440	2,160	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,644	35,886	31,838	1,431	2,298	52.00
53.00	05300	ANESTHESIOLOGY	2,957	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	57,443	8,060	7,151	350	1,467	54.00
56.00	05600	RADIOISOTOPE	4,525	991	879	43	183	56.00
57.00	05700	CT SCAN	19,343	12,475	11,068	541	2,269	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	9,957	2,727	2,419	118	495	58.00
59.00	05900	CARDIAC CATHETERIZATION	20,141	0	0	140	0	59.00
60.00	06000	LABORATORY	76,911	10,644	9,443	0	1,137	60.00
65.00	06500	RESPIRATORY THERAPY	25,014	6,997	6,208	0	2,817	65.00
66.00	06600	PHYSICAL THERAPY	33,635	33,321	29,563	91	2,900	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,160	22,506	19,968	797	94	67.00
68.00	06800	SPEECH PATHOLOGY	14,751	8,341	7,400	35	59	68.00
68.01	03040	AUDIOLOGY	2,939	537	476	7	12	68.01
69.00	06900	ELECTROCARDIOLOGY	9,232	0	0	57	0	69.00
69.01	03160	CARDIOPULMONARY	9,547	5,639	5,003	0	383	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	950	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	163,434	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,980	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,504	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	76,051	12,596	11,175	0	0	90.00
91.00	09100	EMERGENCY	102,487	34,216	30,357	1,929	7,968	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	17,791	2,152	1,909	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,364,364	386,638	305,712	12,663	63,520	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	257	2,473	2,194	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,415	52,103	46,230	0	0	192.00
193.00	19300	NONPAID WORKERS	3,688	35,486	31,483	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,373,724	476,700	385,619	12,663	63,520	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	130,884					10.00
11.00	01100	CAFETERIA	0	24,307				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,791	41,847			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,104	0	250,609		14.00
15.00	01500	PHARMACY	0	667	0	265	468,981	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,240	0	1	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	542	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	95,839	7,402	16,777	4,864	1,165	30.00
31.00	03100	INTENSIVE CARE UNIT	12,145	1,161	3,102	1,935	183	31.00
41.00	04100	SUBPROVIDER - IRF	22,900	1,017	0	281	34	41.00
43.00	04300	NURSERY	0	188	749	302	9	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	882	8,933	10,522	98	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	445	1,766	713	20	52.00
53.00	05300	ANESTHESIOLOGY	0	300	0	744	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	440	0	419	0	54.00
56.00	05600	RADIOISOTOPE	0	54	0	35	0	56.00
57.00	05700	CT SCAN	0	681	0	857	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	149	0	23	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	1,049	188	40	59.00
60.00	06000	LABORATORY	0	1,004	0	25,801	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	992	0	1,206	0	65.00
66.00	06600	PHYSICAL THERAPY	0	426	0	112	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	270	0	51	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	163	0	3	0	68.00
68.01	03040	AUDIOLOGY	0	32	0	45	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	339	0	87	0	69.00
69.01	03160	CARDIOPULMONARY	0	474	885	117	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	198,634	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	467,342	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	169	0	90.00
91.00	09100	EMERGENCY	0	2,088	8,586	3,169	90	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	63	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	130,884	23,851	41,847	250,609	468,981	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	456	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	130,884	24,307	41,847	250,609	468,981	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	136,822					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	1,385			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,523	0		906,893	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,238	0		203,143	0	31.00
41.00	04100	SUBPROVIDER - IRF	1,577	0		135,750	0	41.00
43.00	04300	NURSERY	1,176	0		37,685	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,064	0		1,083,650	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,777	0		399,815	0	52.00
53.00	05300	ANESTHESIOLOGY	2,974	0		42,553	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,099	0		623,137	0	54.00
56.00	05600	RADIOISOTOPE	1,119	0		21,844	0	56.00
57.00	05700	CT SCAN	14,081	0		555,992	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	3,078	0		322,512	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,493	0		414,517	0	59.00
60.00	06000	LABORATORY	18,649	0		440,745	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,749	0		185,203	0	65.00
66.00	06600	PHYSICAL THERAPY	3,256	0		370,602	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,198	0		237,964	0	67.00
68.00	06800	SPEECH PATHOLOGY	816	0		96,672	0	68.00
68.01	03040	AUDIOLOGY	268	0		12,711	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,374	0		80,681	0	69.00
69.01	03160	CARDIOPULMONARY	522	0		80,702	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	358	0		6,724	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,953	0		369,021	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,395	0		504,822	0	73.00
74.00	07400	RENAL DIALYSIS	349	0		3,853	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	2,011	0		880,416	0	90.00
91.00	09100	EMERGENCY	15,426	0		543,335	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	299	0		38,884	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,822	0	0	8,599,826	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		23,086	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		486,896	0	192.00
193.00	19300	NONPAID WORKERS	0	0		331,282	0	193.00
200.00		Cross Foot Adjustments			1,385	1,385	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	136,822	0	1,385	9,442,475	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B Part II | Date/Time Prepared: 5/30/2018 9:08 am

		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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
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
23.00	02300	PARAMEDICAL EDUCATION PRGM			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	906,893		30.00
31.00	03100	INTENSIVE CARE UNIT	203,143		31.00
41.00	04100	SUBPROVIDER - IRF	135,750		41.00
43.00	04300	NURSERY	37,685		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,083,650		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	399,815		52.00
53.00	05300	ANESTHESIOLOGY	42,553		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,137		54.00
56.00	05600	RADIOISOTOPE	21,844		56.00
57.00	05700	CT SCAN	555,992		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	322,512		58.00
59.00	05900	CARDIAC CATHETERIZATION	414,517		59.00
60.00	06000	LABORATORY	440,745		60.00
65.00	06500	RESPIRATORY THERAPY	185,203		65.00
66.00	06600	PHYSICAL THERAPY	370,602		66.00
67.00	06700	OCCUPATIONAL THERAPY	237,964		67.00
68.00	06800	SPEECH PATHOLOGY	96,672		68.00
68.01	03040	AUDIOLOGY	12,711		68.01
69.00	06900	ELECTROCARDIOLOGY	80,681		69.00
69.01	03160	CARDIOPULMONARY	80,702		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,724		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,021		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	504,822		73.00
74.00	07400	RENAL DIALYSIS	3,853		74.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	880,416		90.00
91.00	09100	EMERGENCY	543,335		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	38,884		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,599,826		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,086		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	486,896		192.00
193.00	19300	NONPAID WORKERS	331,282		193.00
200.00		Cross Foot Adjustments	1,385		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	9,442,475		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	449,735					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,271,072				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,248	25,066	51,674,602			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,148	932,307	8,254,464	-21,046,243	97,072,728	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,895	398,746	1,093,379	0	2,619,321	6.00
7.00	00700	OPERATION OF PLANT	36,124	0	0	0	2,449,650	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	0	58,227	0	566,892	8.00
9.00	00900	HOUSEKEEPING	2,964	5,564	1,179,265	0	1,769,988	9.00
10.00	01000	DIETARY	10,317	8,525	278,859	0	760,310	10.00
11.00	01100	CAFETERIA	0	4,084	582,138	0	1,388,796	11.00
13.00	01300	NURSING ADMINISTRATION	2,776	0	556,945	0	694,192	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,743	58,453	735,369	0	1,251,899	14.00
15.00	01500	PHARMACY	2,468	93,358	0	0	5,826,931	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,830	12,018	1,145,280	0	1,886,555	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	58,703	0	56,589	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,441	137,154	9,016,372	0	12,008,359	30.00
31.00	03100	INTENSIVE CARE UNIT	9,203	35,407	1,922,211	0	2,636,478	31.00
41.00	04100	SUBPROVIDER - IRF	7,085	1,844	923,174	0	1,830,973	41.00
43.00	04300	NURSERY	1,022	13,441	475,489	0	636,555	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,405	399,008	5,127,486	0	9,049,346	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,823	31,751	1,122,648	0	1,741,476	52.00
53.00	05300	ANESTHESIOLOGY	0	21,216	0	0	208,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,923	187,834	2,125,751	0	4,059,324	54.00
56.00	05600	RADIOISOTOPE	851	6,373	168,741	0	319,769	56.00
57.00	05700	CT SCAN	10,715	122,628	373,482	0	1,366,916	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,342	18,599	165,920	0	703,627	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	215,340	778,348	0	1,423,291	59.00
60.00	06000	LABORATORY	9,142	195,874	1,418,346	0	5,435,030	60.00
65.00	06500	RESPIRATORY THERAPY	6,010	58,637	1,174,046	0	1,767,654	65.00
66.00	06600	PHYSICAL THERAPY	28,620	10,930	1,663,010	0	2,376,835	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,331	1,447	935,663	0	1,353,939	67.00
68.00	06800	SPEECH PATHOLOGY	7,164	0	770,066	0	1,042,367	68.00
68.01	03040	AUDIOLOGY	461	3,567	154,881	0	207,655	68.01
69.00	06900	ELECTROCARDIOLOGY	0	39,857	395,785	0	652,417	69.00
69.01	03160	CARDIOPULMONARY	4,843	15,748	515,884	0	674,673	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,179	49,097	0	67,108	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	11,549,286	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,555,898	0	1,906,573	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	247,608	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,819	135,604	687,090	0	5,374,264	90.00
91.00	09100	EMERGENCY	29,389	75,323	5,267,518	0	7,242,392	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,848	190	945,067	0	1,257,253	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	372,378	3,271,072	51,674,602	-21,046,243	96,411,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	0	0	0	18,162	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,754	0	0	0	382,692	192.00
193.00	19300	NONPAID WORKERS	30,479	0	0	0	260,625	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,845,676	3,396,991	11,646,637		21,046,243	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.550982	1.038495	0.225384		0.216809	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			36,703		1,373,724	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000710		0.014151	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:08 am

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	409,444					6.00
7.00	00700	OPERATION OF PLANT	36,124	373,320				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	428	428	1,098,557			8.00
9.00	00900	HOUSEKEEPING	2,964	2,964	0	10,778		9.00
10.00	01000	DIETARY	10,317	10,317	0	0	111,268	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,776	2,776	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,743	10,743	20,515	154	0	14.00
15.00	01500	PHARMACY	2,468	2,468	0	118	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,830	8,830	0	116	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	39,441	39,441	353,238	4,158	81,475	30.00
31.00	03100	INTENSIVE CARE UNIT	9,203	9,203	56,892	1,419	10,325	31.00
41.00	04100	SUBPROVIDER - IRF	7,085	7,085	0	901	19,468	41.00
43.00	04300	NURSERY	1,022	1,022	0	165	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,405	31,405	187,346	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,823	30,823	124,173	390	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,923	6,923	30,335	249	0	54.00
56.00	05600	RADIOISOTOPE	851	851	3,728	31	0	56.00
57.00	05700	CT SCAN	10,715	10,715	46,947	385	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,342	2,342	10,263	84	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	12,108	0	0	59.00
60.00	06000	LABORATORY	9,142	9,142	0	193	0	60.00
65.00	06500	RESPIRATORY THERAPY	6,010	6,010	0	478	0	65.00
66.00	06600	PHYSICAL THERAPY	28,620	28,620	7,918	492	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,331	19,331	69,154	16	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,164	7,164	3,033	10	0	68.00
68.01	03040	AUDIOLOGY	461	461	588	2	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	4,983	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,843	4,843	0	65	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	10,819	10,819	0	0	0	90.00
91.00	09100	EMERGENCY	29,389	29,389	167,336	1,352	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,848	1,848	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	332,087	295,963	1,098,557	10,778	111,268	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,124	2,124	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	44,754	44,754	0	0	0	192.00
193.00	19300	NONPAID WORKERS	30,479	30,479	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,187,213	3,261,954	696,871	2,202,709	1,095,609	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.784246	8.737689	0.634351	204.370848	9.846578	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	476,700	385,619	12,663	63,520	130,884	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.164262	1.032945	0.011527	5.893487	1.176295	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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	29,143					11.00
13.00	01300	NURSING ADMINISTRATION	2,147	11,683				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,324	0	14,221,638			14.00
15.00	01500	PHARMACY	800	0	15,011	2,615,450		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,487	0	56	0	57,697	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	650	0	11	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,872	4,684	276,012	6,497	4,016	30.00
31.00	03100	INTENSIVE CARE UNIT	1,392	866	109,826	1,018	522	31.00
41.00	04100	SUBPROVIDER - IRF	1,219	0	15,944	189	665	41.00
43.00	04300	NURSERY	226	209	17,137	48	496	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,057	2,494	597,120	549	8,039	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	533	493	40,483	113	1,171	52.00
53.00	05300	ANESTHESIOLOGY	360	0	42,219	0	1,254	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	528	0	23,783	0	3,837	54.00
56.00	05600	RADIOISOTOPE	65	0	1,982	0	472	56.00
57.00	05700	CT SCAN	817	0	48,656	0	5,938	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	179	0	1,296	0	1,298	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	293	10,690	223	1,473	59.00
60.00	06000	LABORATORY	1,204	0	1,464,158	0	7,864	60.00
65.00	06500	RESPIRATORY THERAPY	1,189	0	68,427	0	1,581	65.00
66.00	06600	PHYSICAL THERAPY	511	0	6,366	0	1,373	66.00
67.00	06700	OCCUPATIONAL THERAPY	324	0	2,867	0	927	67.00
68.00	06800	SPEECH PATHOLOGY	196	0	185	0	344	68.00
68.01	03040	AUDIOLOGY	38	0	2,542	0	113	68.01
69.00	06900	ELECTROCARDIOLOGY	406	0	4,956	0	1,423	69.00
69.01	03160	CARDIOPULMONARY	568	247	6,646	0	220	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	164	0	151	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	11,272,095	0	2,932	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,606,312	3,962	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	147	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	9,594	0	848	90.00
91.00	09100	EMERGENCY	2,504	2,397	179,825	501	6,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	3,587	0	126	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,596	11,683	14,221,638	2,615,450	57,697	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	547	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,689,899	1,015,061	1,822,078	7,203,467	2,551,406	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	57.986446	86.883592	0.128120	2.754198	44.220774	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,307	41,847	250,609	468,981	136,822	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.834060	3.581871	0.017622	0.179312	2.371388	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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet B-1 | Date/Time Prepared: 5/30/2018 9:08 am

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)		
			17.00	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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
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	0			17.00
23.00	02300	PARAMEDICAL EDUCATION PRGM	0	100		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	03040	AUDIOLOGY	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES 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
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	100		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	106,550		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1,065.500000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,385		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	13.850000		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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:08 am

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		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	18,291,891		18,291,891	0	18,291,891	30.00
31.00	03100	INTENSIVE CARE UNIT	3,983,814		3,983,814	0	3,983,814	31.00
41.00	04100	SUBPROVIDER - IRF	2,823,489		2,823,489	0	2,823,489	41.00
43.00	04300	NURSERY	880,698		880,698	0	880,698	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,360,525		12,360,525	0	12,360,525	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,917,796		2,917,796	0	2,917,796	52.00
53.00	05300	ANESTHESIOLOGY	335,999		335,999	72,795	408,794	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,327,273		5,327,273	65,227	5,392,500	54.00
56.00	05600	RADIOISOTOPE	436,753		436,753	0	436,753	56.00
57.00	05700	CT SCAN	2,264,964		2,264,964	0	2,264,964	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	986,497		986,497	0	986,497	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,832,132		1,832,132	10,666	1,842,798	59.00
60.00	06000	LABORATORY	7,409,037		7,409,037	0	7,409,037	60.00
65.00	06500	RESPIRATORY THERAPY	2,495,509	0	2,495,509	0	2,495,509	65.00
66.00	06600	PHYSICAL THERAPY	3,561,747	0	3,561,747	0	3,561,747	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,074,156	0	2,074,156	0	2,074,156	67.00
68.00	06800	SPEECH PATHOLOGY	1,417,294	0	1,417,294	0	1,417,294	68.00
68.01	03040	AUDIOLOGY	268,601	0	268,601	0	268,601	68.01
69.00	06900	ELECTROCARDIOLOGY	884,131		884,131	0	884,131	69.00
69.01	03160	CARDIOPULMONARY	979,224		979,224	0	979,224	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	88,356		88,356	0	88,356	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,627,111		15,627,111	0	15,627,111	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,673,437		9,673,437	0	9,673,437	73.00
74.00	07400	RENAL DIALYSIS	307,792		307,792	0	307,792	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	6,756,932		6,756,932	0	6,756,932	90.00
91.00	09100	EMERGENCY	10,452,713		10,452,713	0	10,452,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,425,616		2,425,616		2,425,616	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,566,401		1,566,401		1,566,401	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	118,429,888	0	118,429,888	148,688	118,578,576	200.00
201.00		Less Observation Beds	2,425,616		2,425,616		2,425,616	201.00
202.00		Total (see instructions)	116,004,272	0	116,004,272	148,688	116,152,960	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:08 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,868,327		24,868,327			30.00
31.00	03100	INTENSIVE CARE UNIT	4,818,145		4,818,145			31.00
41.00	04100	SUBPROVIDER - IRF	6,144,060		6,144,060			41.00
43.00	04300	NURSERY	4,578,527		4,578,527			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,516,119	53,714,831	74,230,950	0.166514	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,232,276	577,819	10,810,095	0.269914	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,055,722	8,527,516	11,583,238	0.029007	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,746,716	29,679,995	35,426,711	0.150374	0.000000	54.00
56.00	05600	RADIOISOTOPE	806,404	3,547,840	4,354,244	0.100305	0.000000	56.00
57.00	05700	CT SCAN	4,994,276	49,833,172	54,827,448	0.041311	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,987,745	9,997,876	11,985,621	0.082307	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,213,928	6,391,715	13,605,643	0.134660	0.000000	59.00
60.00	06000	LABORATORY	25,267,124	47,349,063	72,616,187	0.102030	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,984,414	5,617,087	14,601,501	0.170908	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,239,465	6,440,043	12,679,508	0.280906	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,983,562	3,580,456	8,564,018	0.242194	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	905,130	2,268,542	3,173,672	0.446579	0.000000	68.00
68.01	03040	AUDIOLOGY	0	1,044,732	1,044,732	0.257100	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	4,776,010	8,363,100	13,139,110	0.067290	0.000000	69.00
69.01	03160	CARDIOPULMONARY	440	2,034,354	2,034,794	0.481240	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	64,307	1,332,760	1,397,067	0.063244	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14,399,442	12,673,958	27,073,400	0.577213	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,131,111	22,453,907	36,585,018	0.264410	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,168,765	186,811	1,355,576	0.227056	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	27,242	7,804,588	7,831,830	0.862753	0.000000	90.00
91.00	09100	EMERGENCY	10,857,472	49,212,050	60,069,522	0.174010	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	3,464,893	8,750,454	12,215,347	0.198571	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,160,090	1,160,090			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	190,231,622	342,542,759	532,774,381			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	190,231,622	342,542,759	532,774,381			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet C Part I Date/Time Prepared: 5/30/2018 9:08 am

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		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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.166514	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.269914	52.00
53.00	05300	ANESTHESIOLOGY	0.035292	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152216	54.00
56.00	05600	RADIOISOTOPE	0.100305	56.00
57.00	05700	CT SCAN	0.041311	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082307	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.135444	59.00
60.00	06000	LABORATORY	0.102030	60.00
65.00	06500	RESPIRATORY THERAPY	0.170908	65.00
66.00	06600	PHYSICAL THERAPY	0.280906	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242194	67.00
68.00	06800	SPEECH PATHOLOGY	0.446579	68.00
68.01	03040	AUDIOLOGY	0.257100	68.01
69.00	06900	ELECTROCARDIOLOGY	0.067290	69.00
69.01	03160	CARDIOPULMONARY	0.481240	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063244	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.577213	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264410	73.00
74.00	07400	RENAL DIALYSIS	0.227056	74.00
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.862753	90.00
91.00	09100	EMERGENCY	0.174010	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.198571	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part I Date/Time Prepared: 5/30/2018 9:08 am

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	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	906,893	0	906,893	25,308	35.83	30.00
31.00	INTENSIVE CARE UNIT	203,143		203,143	2,350	86.44	31.00
41.00	SUBPROVIDER - IRF	135,750	0	135,750	4,431	30.64	41.00
43.00	NURSERY	37,685		37,685	3,292	11.45	43.00
200.00	Total (lines 30 through 199)	1,283,471		1,283,471	35,381		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	8,626	309,070		30.00
31.00	INTENSIVE CARE UNIT	884	76,413		31.00
41.00	SUBPROVIDER - IRF	2,741	83,984		41.00
43.00	NURSERY	0	0		43.00
200.00	Total (lines 30 through 199)	12,251	469,467		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/30/2018 9:08 am

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		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,083,650	74,230,950	0.014598	6,677,636	97,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	399,815	10,810,095	0.036985	21,425	792	52.00
53.00	05300	ANESTHESIOLOGY	42,553	11,583,238	0.003674	1,012,055	3,718	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,137	35,426,711	0.017589	3,483,847	61,277	54.00
56.00	05600	RADIOISOTOPE	21,844	4,354,244	0.005017	438,141	2,198	56.00
57.00	05700	CT SCAN	555,992	54,827,448	0.010141	4,929,976	49,995	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	322,512	11,985,621	0.026908	944,806	25,423	58.00
59.00	05900	CARDIAC CATHETERIZATION	414,517	13,605,643	0.030467	2,270,132	69,164	59.00
60.00	06000	LABORATORY	440,745	72,616,187	0.006070	11,875,097	72,082	60.00
65.00	06500	RESPIRATORY THERAPY	185,203	14,601,501	0.012684	4,587,259	58,185	65.00
66.00	06600	PHYSICAL THERAPY	370,602	12,679,508	0.029228	1,800,109	52,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,964	8,564,018	0.027786	972,016	27,008	67.00
68.00	06800	SPEECH PATHOLOGY	96,672	3,173,672	0.030461	254,105	7,740	68.00
68.01	03040	AUDIOLOGY	12,711	1,044,732	0.012167	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	80,681	13,139,110	0.006141	2,583,557	15,866	69.00
69.01	03160	CARDIOPULMONARY	80,702	2,034,794	0.039661	359	14	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,724	1,397,067	0.004813	30,696	148	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,021	27,073,400	0.013630	6,067,146	82,695	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	504,822	36,585,018	0.013799	5,899,953	81,413	73.00
74.00	07400	RENAL DIALYSIS	3,853	1,355,576	0.002842	651,868	1,853	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	880,416	7,831,830	0.112415	26,007	2,924	90.00
91.00	09100	EMERGENCY	543,335	60,069,522	0.009045	5,043,678	45,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	120,260	12,215,347	0.009845	1,504,557	14,812	92.00
200.00		Total (lines 50 through 199)	7,397,731	491,205,232		61,074,425	773,021	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part III Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	25,308	0.00	8,626	30.00
31.00	03100	INTENSIVE CARE UNIT		0	2,350	0.00	884	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	4,431	0.00	2,741	41.00
43.00	04300	NURSERY		0	3,292	0.00	0	43.00
200.00		Total (lines 30 through 199)		0	35,381		12,251	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
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	106,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	106,550	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	74,230,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,810,095	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,583,238	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,426,711	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,354,244	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	54,827,448	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,985,621	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	13,605,643	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	72,616,187	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,601,501	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,679,508	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,564,018	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,173,672	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	1,044,732	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,139,110	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	2,034,794	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,397,067	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	27,073,400	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,585,018	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,355,576	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	7,831,830	0.000000	90.00
91.00	09100	EMERGENCY	0	106,550	106,550	60,069,522	0.001774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	12,215,347	0.000000	92.00
200.00		Total (lines 50 through 199)	0	106,550	106,550	491,205,232		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	6,677,636	0	11,616,073	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	21,425	0	27,754	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,012,055	0	1,733,828	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,483,847	0	4,903,844	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	438,141	0	1,013,894	0	56.00
57.00	05700	CT SCAN	0.000000	4,929,976	0	11,232,721	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	944,806	0	2,589,241	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,270,132	0	2,202,166	0	59.00
60.00	06000	LABORATORY	0.000000	11,875,097	0	6,472,655	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,587,259	0	1,461,085	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,800,109	0	77,092	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	972,016	0	42,525	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	254,105	0	10,239	0	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	127,817	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,583,557	0	2,167,319	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	359	0	878,579	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	30,696	0	252,519	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6,067,146	0	3,771,389	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,899,953	0	6,247,003	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	651,868	0	45,950	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	26,007	0	2,135,650	0	90.00
91.00	09100	EMERGENCY	0.001774	5,043,678	8,947	7,552,091	13,397	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	1,504,557	0	2,095,263	0	92.00
200.00		Total (lines 50 through 199)		61,074,425	8,947	68,656,697	13,397	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.166514	11,616,073	0	0	1,934,239	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.269914	27,754	0	0	7,491	52.00
53.00	05300	ANESTHESIOLOGY	0.029007	1,733,828	0	0	50,293	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150374	4,903,844	0	0	737,411	54.00
56.00	05600	RADIOISOTOPE	0.100305	1,013,894	0	0	101,699	56.00
57.00	05700	CT SCAN	0.041311	11,232,721	0	0	464,035	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082307	2,589,241	0	0	213,113	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.134660	2,202,166	0	0	296,544	59.00
60.00	06000	LABORATORY	0.102030	6,472,655	681	0	660,405	60.00
65.00	06500	RESPIRATORY THERAPY	0.170908	1,461,085	0	0	249,711	65.00
66.00	06600	PHYSICAL THERAPY	0.280906	77,092	0	0	21,656	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242194	42,525	0	0	10,299	67.00
68.00	06800	SPEECH PATHOLOGY	0.446579	10,239	0	0	4,573	68.00
68.01	03040	AUDIOLOGY	0.257100	127,817	0	0	32,862	68.01
69.00	06900	ELECTROCARDIOLOGY	0.067290	2,167,319	0	0	145,839	69.00
69.01	03160	CARDIOPULMONARY	0.481240	878,579	0	0	422,807	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063244	252,519	0	0	15,970	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.577213	3,771,389	0	0	2,176,895	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264410	6,247,003	0	29,295	1,651,770	73.00
74.00	07400	RENAL DIALYSIS	0.227056	45,950	0	0	10,433	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.862753	2,135,650	0	0	1,842,538	90.00
91.00	09100	EMERGENCY	0.174010	7,552,091	0	0	1,314,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.198571	2,095,263	0	0	416,058	92.00
200.00		Subtotal (see instructions)		68,656,697	681	29,295	12,780,780	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		68,656,697	681	29,295	12,780,780	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part V Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	69	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	03040	AUDIOLOGY	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,746		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	69	7,746		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	69	7,746		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part II Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,083,650	74,230,950	0.014598	30,609	447	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	399,815	10,810,095	0.036985	0	0	52.00
53.00	05300	ANESTHESIOLOGY	42,553	11,583,238	0.003674	4,249	16	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	623,137	35,426,711	0.017589	115,355	2,029	54.00
56.00	05600	RADIOISOTOPE	21,844	4,354,244	0.005017	4,919	25	56.00
57.00	05700	CT SCAN	555,992	54,827,448	0.010141	64,300	652	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	322,512	11,985,621	0.026908	32,232	867	58.00
59.00	05900	CARDIAC CATHETERIZATION	414,517	13,605,643	0.030467	948	29	59.00
60.00	06000	LABORATORY	440,745	72,616,187	0.006070	510,266	3,097	60.00
65.00	06500	RESPIRATORY THERAPY	185,203	14,601,501	0.012684	231,575	2,937	65.00
66.00	06600	PHYSICAL THERAPY	370,602	12,679,508	0.029228	1,757,620	51,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	237,964	8,564,018	0.027786	1,942,661	53,979	67.00
68.00	06800	SPEECH PATHOLOGY	96,672	3,173,672	0.030461	242,511	7,387	68.00
68.01	03040	AUDIOLOGY	12,711	1,044,732	0.012167	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	80,681	13,139,110	0.006141	20,472	126	69.00
69.01	03160	CARDIOPULMONARY	80,702	2,034,794	0.039661	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	6,724	1,397,067	0.004813	1,254	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	369,021	27,073,400	0.013630	89,320	1,217	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	504,822	36,585,018	0.013799	595,226	8,214	73.00
74.00	07400	RENAL DIALYSIS	3,853	1,355,576	0.002842	71,482	203	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	880,416	7,831,830	0.112415	0	0	90.00
91.00	09100	EMERGENCY	543,335	60,069,522	0.009045	16,250	147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	12,215,347	0.000000	58,471	0	92.00
200.00		Total (lines 50 through 199)	7,277,471	491,205,232		5,789,720	132,750	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 9:08 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	03040	AUDIOLOGY	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES 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
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	106,550	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	106,550	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 9:08 am

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	74,230,950	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	10,810,095	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,583,238	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	35,426,711	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	4,354,244	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	54,827,448	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	11,985,621	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	13,605,643	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	72,616,187	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,601,501	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,679,508	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	8,564,018	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3,173,672	0.000000	68.00
68.01	03040	AUDIOLOGY	0	0	0	1,044,732	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,139,110	0.000000	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	2,034,794	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,397,067	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	27,073,400	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,585,018	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,355,576	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	7,831,830	0.000000	90.00
91.00	09100	EMERGENCY	0	106,550	106,550	60,069,522	0.001774	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	12,215,347	0.000000	92.00
200.00		Total (lines 50 through 199)	0	106,550	106,550	491,205,232		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D Part IV Date/Time Prepared: 5/30/2018 9:08 am

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	30,609	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,249	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	115,355	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	4,919	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	64,300	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	32,232	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	948	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	510,266	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	231,575	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,757,620	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,942,661	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	242,511	0	0	0	68.00
68.01	03040	AUDIOLOGY	0.000000	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	20,472	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,254	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	89,320	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	595,226	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	71,482	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.001774	16,250	29	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	58,471	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,789,720	29	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	25,308	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,308	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)	21,952	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	8,626	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)	18,291,891	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)	18,291,891	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)	18,291,891	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)	722.77	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,234,614	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)	6,234,614	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	3,983,814	2,350	1,695.24	884	1,498,592	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)	11,751,602	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	19,484,808	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)	385,483	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	781,968	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,167,451	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	18,317,357	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	3,356	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	722.77	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,425,616	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	906,893	18,291,891	0.049579	2,425,616	120,260	90.00
91.00	Nursing School cost	0	18,291,891	0.000000	2,425,616	0	91.00
92.00	Allied health cost	0	18,291,891	0.000000	2,425,616	0	92.00
93.00	All other Medical Education	0	18,291,891	0.000000	2,425,616	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/30/2018 9:08 am
	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)	4,431	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,431	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	4,431	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)	2,741	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)	2,823,489	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)	2,823,489	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)	2,823,489	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)	637.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,746,593	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,746,593	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	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)	1,433,970	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,180,563	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)	83,984	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	132,779	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	216,763	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,963,800	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: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-1 | Date/Time Prepared: 5/30/2018 9:08 am

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	135,750	2,823,489	0.048079	0	0	90.00
91.00	Nursing School cost	0	2,823,489	0.000000	0	0	91.00
92.00	Allied health cost	0	2,823,489	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,823,489	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		9,737,148		30.00
31.00	03100	INTENSIVE CARE UNIT		1,972,328		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	0.166514	6,677,636	1,111,920	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.269914	21,425	5,783	52.00
53.00	05300	ANESTHESIOLOGY	0.035292	1,012,055	35,717	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152216	3,483,847	530,297	54.00
56.00	05600	RADIOISOTOPE	0.100305	438,141	43,948	56.00
57.00	05700	CT SCAN	0.041311	4,929,976	203,662	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082307	944,806	77,764	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.135444	2,270,132	307,476	59.00
60.00	06000	LABORATORY	0.102030	11,875,097	1,211,616	60.00
65.00	06500	RESPIRATORY THERAPY	0.170908	4,587,259	783,999	65.00
66.00	06600	PHYSICAL THERAPY	0.280906	1,800,109	505,661	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242194	972,016	235,416	67.00
68.00	06800	SPEECH PATHOLOGY	0.446579	254,105	113,478	68.00
68.01	03040	AUDIOLOGY	0.257100	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.067290	2,583,557	173,848	69.00
69.01	03160	CARDIOPULMONARY	0.481240	359	173	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063244	30,696	1,941	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.577213	6,067,146	3,502,036	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264410	5,899,953	1,560,007	73.00
74.00	07400	RENAL DIALYSIS	0.227056	651,868	148,011	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.862753	26,007	22,438	90.00
91.00	09100	EMERGENCY	0.174010	5,043,678	877,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.198571	1,504,557	298,761	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		61,074,425	11,751,602	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)		61,074,425		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet D-3 | Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		3,809,347		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.166514	30,609	5,097	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.269914	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.035292	4,249	150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.152216	115,355	17,559	54.00
56.00	05600	RADIOISOTOPE	0.100305	4,919	493	56.00
57.00	05700	CT SCAN	0.041311	64,300	2,656	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.082307	32,232	2,653	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.135444	948	128	59.00
60.00	06000	LABORATORY	0.102030	510,266	52,062	60.00
65.00	06500	RESPIRATORY THERAPY	0.170908	231,575	39,578	65.00
66.00	06600	PHYSICAL THERAPY	0.280906	1,757,620	493,726	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.242194	1,942,661	470,501	67.00
68.00	06800	SPEECH PATHOLOGY	0.446579	242,511	108,300	68.00
68.01	03040	AUDIOLOGY	0.257100	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.067290	20,472	1,378	69.00
69.01	03160	CARDIOPULMONARY	0.481240	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.063244	1,254	79	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.577213	89,320	51,557	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.264410	595,226	157,384	73.00
74.00	07400	RENAL DIALYSIS	0.227056	71,482	16,230	74.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.862753	0	0	90.00
91.00	09100	EMERGENCY	0.174010	16,250	2,828	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.198571	58,471	11,611	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,789,720	1,433,970	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)		5,789,720		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 9:08 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	12,851,241	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,283,747	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)	332,615	2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
3.00	Managed Care Simulated Payments	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	120.81	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.43	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.51	31.00
32.00	Sum of lines 30 and 31	20.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)	6.49	33.00
34.00	Disproportionate share adjustment (see instructions)	278,016	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 9:08 am
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	869,930	809,112	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	650,660	203,941	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	854,601		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)	18,600,220		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)	18,600,220	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,458,425	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	29,930	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)	8,947	58.00
59.00	Total (sum of amounts on lines 49 through 58)	20,097,522	59.00
60.00	Primary payer payments	81,281	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	20,016,241	61.00
62.00	Deductibles billed to program beneficiaries	2,273,040	62.00
63.00	Coinsurance billed to program beneficiaries	55,601	63.00
64.00	Allowable bad debts (see instructions)	491,048	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	319,181	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	439,574	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,006,781	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)	-128,425	70.93
70.94	HRR adjustment amount (see instructions)	-32,246	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Prepared: 5/30/2018 9:08 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		17,846,110	71.00
71.01	Sequestration adjustment (see instructions)		356,922	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		17,502,038	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)		-12,850	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		157,556	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/30/2018 9:08 am
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,815	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	12,767,383	2.00
3.00	OPPS payments	11,433,235	3.00
4.00	Outlier payment (see instructions)	20,836	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	13,397	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,815	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	29,976	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)	29,976	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)	29,976	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	22,161	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)	7,815	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)	11,467,468	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)	2,199,236	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)	9,276,047	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)	9,276,047	30.00
31.00	Primary payer payments	2,251	31.00
32.00	Subtotal (line 30 minus line 31)	9,273,796	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)	299,206	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	194,484	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	236,265	36.00
37.00	Subtotal (see instructions)	9,468,280	37.00
38.00	MSP-LCC reconciliation amount from PS&R	535	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)	9,467,745	40.00
40.01	Sequestration adjustment (see instructions)	189,355	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	9,253,855	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	24,535	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I Date/Time Prepared: 5/30/2018 9:08 am

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		17,502,038		9,253,855	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)		17,502,038		9,253,855	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		24,535	6.01
6.02	SETTLEMENT TO PROGRAM		12,850		0	6.02
7.00	Total Medicare program liability (see instructions)		17,489,188		9,278,390	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: 14-0289 | Component CCN: 14-T289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2018 9:08 am

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		3,652,817		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)		3,652,817		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		12,798		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,665,615		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: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet E-1 Part II Date/Time Prepared: 5/30/2018 9:08 am
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0289 Component CCN: 14-T289	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part III Date/Time Prepared: 5/30/2018 9:08 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	3,618,014	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0348	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	134,228	3.00
4.00	Outlier Payments	57,115	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)	12.139726	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)	3,809,357	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)	3,809,357	17.00
18.00	Primary payer payments	5,975	18.00
19.00	Subtotal (line 17 less line 18).	3,803,382	19.00
20.00	Deductibles	57,904	20.00
21.00	Subtotal (line 19 minus line 20)	3,745,478	21.00
22.00	Coinsurance	17,766	22.00
23.00	Subtotal (line 21 minus line 22)	3,727,712	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	19,511	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	12,682	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	12,999	26.00
27.00	Subtotal (sum of lines 23 and 25)	3,740,394	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)	29	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)	3,740,423	32.00
32.01	Sequestration adjustment (see instructions)	74,808	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	3,652,817	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)	12,798	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	57,115	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

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G | Date/Time Prepared: 5/30/2018 9:08 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,617,755	0	0	0	1.00
2.00	Temporary investments	1,523,592	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	18,721,810	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,661,031	0	0	0	7.00
8.00	Prepaid expenses	1,958,441	0	0	0	8.00
9.00	Other current assets	7,874,012	0	0	0	9.00
10.00	Due from other funds	158,004	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	36,514,645	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	963,454	0	0	0	12.00
13.00	Land improvements	3,118,215	0	0	0	13.00
14.00	Accumulated depreciation	-2,401,820	0	0	0	14.00
15.00	Buildings	108,298,647	0	0	0	15.00
16.00	Accumulated depreciation	-44,302,737	0	0	0	16.00
17.00	Leasehold improvements	24,000	0	0	0	17.00
18.00	Accumulated depreciation	-24,000	0	0	0	18.00
19.00	Fixed equipment	5,371,373	0	0	0	19.00
20.00	Accumulated depreciation	-3,807,889	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	40,791,617	0	0	0	23.00
24.00	Accumulated depreciation	-30,364,607	0	0	0	24.00
25.00	Minor equipment depreciable	83,185	0	0	0	25.00
26.00	Accumulated depreciation	-83,185	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	434,286	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	78,100,539	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	106,178,557	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	4,916,352	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	111,094,909	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	225,710,093	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	3,272,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,895,766	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,609,111	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	5,239,106	0	0	0	43.00
44.00	Other current liabilities	6,189,282	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	23,205,265	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	32,383,534	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	15,325,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	47,708,534	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	70,913,799	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	154,796,294				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)	154,796,294	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	225,710,093	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-1 | Date/Time Prepared: 5/30/2018 9:08 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		134,329,113		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		28,760,667				2.00
3.00	Total (sum of line 1 and line 2)		163,089,780		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		163,089,780		0		11.00
12.00	TRANSFERS	8,293,486		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)		8,293,486		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		154,796,294		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			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	TRANSFERS		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: 14-0289 | Period: From 01/01/2017 To 12/31/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/30/2018 9:08 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	29,446,854		29,446,854	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	6,144,060		6,144,060	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	35,590,914		35,590,914	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	4,818,145		4,818,145	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)	4,818,145		4,818,145	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	40,409,059		40,409,059	17.00
18.00	Ancillary services	134,775,824	276,312,709	411,088,533	18.00
19.00	Outpatient services	14,349,606	65,767,092	80,116,698	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		1,160,090	1,160,090	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	189,534,489	343,239,891	532,774,380	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		129,476,738		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		129,476,738		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Prepared: 5/30/2018 9:08 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	532,774,380	1.00
2.00	Less contractual allowances and discounts on patients' accounts	387,499,436	2.00
3.00	Net patient revenues (line 1 minus line 2)	145,274,944	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	129,476,738	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,798,206	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	10,763,674	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	5	10.00
11.00	Rebates and refunds of expenses	1,502	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	0	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	104,435	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	1,110,995	22.00
23.00	Governmental appropriations	0	23.00
24.00	MANAGEMENT FEES	163,200	24.00
24.01	SISHA INCOME	211,560	24.01
24.02	MISC INCOME	667,414	24.02
25.00	Total other income (sum of lines 6-24)	13,022,785	25.00
26.00	Total (line 5 plus line 25)	28,820,991	26.00
27.00	LOSS ON DISPOSAL OF INCOME	60,324	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	60,324	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	28,760,667	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H | Date/Time Prepared: 5/30/2018 9:08 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	195,299	0	0	0	21,211	216,510	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	452,515	0	18,123	0	0	470,638	6.00
7.00	Physical Therapy	162,373	0	13,611	19,151	0	195,135	7.00
8.00	Occupational Therapy	68,103	0	5,700	0	0	73,803	8.00
9.00	Speech Pathology	9,154	0	767	0	0	9,921	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	57,624	0	3,757	0	0	61,381	11.00
12.00	Supplies (see instructions)	0	0	0	0	10,056	10,056	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	945,068	0	41,958	19,151	31,267	1,037,444	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-2,724	213,786	0	213,786			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	470,638	0	470,638			6.00
7.00	Physical Therapy	0	195,135	0	195,135			7.00
8.00	Occupational Therapy	0	73,803	0	73,803			8.00
9.00	Speech Pathology	0	9,921	0	9,921			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	61,381	0	61,381			11.00
12.00	Supplies (see instructions)	-6,469	3,587	0	3,587			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-9,193	1,028,251	0	1,028,251			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part I | Date/Time Prepared: 5/30/2018 9:08 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	213,786	0	0	0	0	213,786	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	470,638	0	0	0	0	470,638	6.00
7.00	Physical Therapy	195,135	0	0	0	0	195,135	7.00
8.00	Occupational Therapy	73,803	0	0	0	0	73,803	8.00
9.00	Speech Pathology	9,921	0	0	0	0	9,921	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	61,381	0	0	0	0	61,381	11.00
12.00	Supplies (see instructions)	3,587	0	0	0	0	3,587	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,028,251	0	0	0	0	1,028,251	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	213,786		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	123,536	594,174	6.00
7.00	Physical Therapy	51,220	246,355	7.00
8.00	Occupational Therapy	19,372	93,175	8.00
9.00	Speech Pathology	2,604	12,525	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	16,112	77,493	11.00
12.00	Supplies (see instructions)	942	4,529	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		1,028,251	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-1 Part II Date/Time Prepared: 5/30/2018 9:08 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-213,786	814,465	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	470,638	6.00
7.00	Physical Therapy	0	0	0	0	0	195,135	7.00
8.00	Occupational Therapy	0	0	0	0	0	73,803	8.00
9.00	Speech Pathology	0	0	0	0	0	9,921	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	61,381	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	3,587	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-213,786	814,465	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		213,786	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.262486	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289
HHA CCN: 14-7420

Period: From 01/01/2017 To 12/31/2017

Worksheet H-2 Part I
Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	15,802	197	44,017	60,016	13,012	1.00
2.00	Skilled Nursing Care	594,174	0	0	101,990	696,164	150,935	2.00
3.00	Physical Therapy	246,355	0	0	36,596	282,951	61,346	3.00
4.00	Occupational Therapy	93,175	0	0	15,349	108,524	23,529	4.00
5.00	Speech Pathology	12,525	0	0	2,063	14,588	3,163	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	77,493	0	0	12,988	90,481	19,617	7.00
8.00	Supplies (see instructions)	4,529	0	0	0	4,529	982	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,028,251	15,802	197	213,003	1,257,253	272,584	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	14,385	16,147	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	14,385	16,147	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part I | Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMEDICAL EDUCATION PRGM	
		13.00	14.00	15.00	16.00	17.00	23.00	
1.00	Administrative and General	0	460	0	5,572	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	460	0	5,572	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	109,592	0	109,592				1.00
2.00	Skilled Nursing Care	847,099	0	847,099	63,726	910,825		2.00
3.00	Physical Therapy	344,297	0	344,297	25,900	370,197		3.00
4.00	Occupational Therapy	132,053	0	132,053	9,934	141,987		4.00
5.00	Speech Pathology	17,751	0	17,751	1,335	19,086		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	110,098	0	110,098	8,282	118,380		7.00
8.00	Supplies (see instructions)	5,511	0	5,511	415	5,926		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	1,566,401	0	1,566,401	109,592	1,566,401		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.075227			21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-2 Part II | Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,848	190	195,298	0	60,016	1,848	1.00
2.00	Skilled Nursing Care	0	0	452,515	0	696,164	0	2.00
3.00	Physical Therapy	0	0	162,373	0	282,951	0	3.00
4.00	Occupational Therapy	0	0	68,103	0	108,524	0	4.00
5.00	Speech Pathology	0	0	9,154	0	14,588	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	57,624	0	90,481	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	4,529	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,848	190	945,067		1,257,253	1,848	20.00
21.00	Total cost to be allocated	15,802	197	213,003		272,584	14,385	21.00
22.00	Unit cost multiplier	8.550866	1.036842	0.225384		0.216809	7.784091	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,848	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	1,848	0	0	0	0	0	20.00
21.00	Total cost to be allocated	16,147	0	0	0	0	0	21.00
22.00	Unit cost multiplier	8.737554	0.000000	0.000000	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0289
HHA CCN: 14-7420

Period: From 01/01/2017 To 12/31/2017

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMEDICAL EDUCATION PRGM (ASSIGNED TIME)		
		14.00	15.00	16.00	17.00	23.00		
1.00	Administrative and General	3,587	0	126	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0	0		19.50
20.00	Total (sum of lines 1-19)	3,587	0	126	0	0		20.00
21.00	Total cost to be allocated	460	0	5,572	0	0		21.00
22.00	Unit cost multiplier	0.128241	0.000000	44.222222	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	910,825		910,825	3,236	281.47	1.00
2.00	Physical Therapy	3.00	370,197	0	370,197	2,431	152.28	2.00
3.00	Occupational Therapy	4.00	141,987	0	141,987	1,018	139.48	3.00
4.00	Speech Pathology	5.00	19,086	0	19,086	137	139.31	4.00
5.00	Medical Social Services	6.00	0		0	1	0.00	5.00
6.00	Home Health Aide	7.00	118,380		118,380	671	176.42	6.00
7.00	Total (sum of lines 1-6)		1,560,475	0	1,560,475	7,494		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		41180	0	1,575			8.00
9.00	Physical Therapy		41180	0	1,113			9.00
10.00	Occupational Therapy		41180	0	477			10.00
11.00	Speech Pathology		41180	0	103			11.00
12.00	Medical Social Services		41180	0	1			12.00
13.00	Home Health Aide		41180	0	375			13.00
14.00	Total (sum of lines 8-13)			0	3,644			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	5,926	0	5,926	12,605	0.470131	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,575		0	443,315		1.00
2.00	Physical Therapy	0	1,113		0	169,488		2.00
3.00	Occupational Therapy	0	477		0	66,532		3.00
4.00	Speech Pathology	0	103		0	14,349		4.00
5.00	Medical Social Services	0	1		0	0		5.00
6.00	Home Health Aide	0	375		0	66,158		6.00
7.00	Total (sum of lines 1-6)	0	3,644		0	759,842		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part I | Date/Time Prepared: 5/30/2018 9:08 am

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

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	12,605	0	0	5,926	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	443,315						1.00
2.00	Physical Therapy	169,488						2.00
3.00	Occupational Therapy	66,532						3.00
4.00	Speech Pathology	14,349						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	66,158						6.00
7.00	Total (sum of lines 1-6)	759,842						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-3 Part II | Date/Time Prepared: 5/30/2018 9:08 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.280906	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.242194	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.446579	0	0	col. 2, line 4.00	3.00
3.01	Speech Pathology 1	68.01	0.257100	0	0	col. 2, line 4.01	3.01
4.00	Cost of Medical Supplies	71.00	0.577213	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.264410	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 5/30/2018 9:08 am

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	614,686	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	37,253	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	27,517	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	4,385	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	11,297	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	235	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	695,373	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	695,373	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	695,373	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	695,373	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	695,373	31.00
31.01	Sequestration adjustment (see instructions)	0	13,906	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	681,467	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0289 | HHA CCN: 14-7420 | Period: From 01/01/2017 To 12/31/2017 | Worksheet H-5 | Date/Time Prepared: 5/30/2018 9:08 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		681,467	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		681,467	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		681,467	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0289	Period: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Prepared: 5/30/2018 9:08 am
	Title XVIII	Hospital	PPS

			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,378,431	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		20,308	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)		67.88	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.43	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		18.51	8.00
9.00	Sum of lines 7 and 8		20.94	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.33	10.00
11.00	Disproportionate share adjustment (see instructions)		59,686	11.00
12.00	Total prospective capital payments (see instructions)		1,458,425	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