

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: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet S Parts I-III Date/Time Prepared: 4/23/2018 11:35 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 4/23/2018	Time: 11:35 am
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 AURORA CHICAGO LAKESHORE (14-4005) 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		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	69,833	22,067	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	69,833	22,067	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: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 4/23/2018 11:33 am						
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 4840 N MARINE DRIVE			PO Box:						1.00		
2.00	City: CHI CAGO			State: IL		Zip Code: 60640-7860		County: COOK		2.00		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
				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		AURORA CHI CAGO LAKESHORE		144005	16974	4	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:		To:			
							1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2017		12/31/2017		20.00	
21.00	Type of Control (see instructions)						4				21.00	
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								0		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.			0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 4/23/2018 11:33 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)	N	N			40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N				60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 4/23/2018 11:33 am		
	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						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.						61.10	0.00 0.00
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.						61.20	0.00 0.00
							1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>								
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)						62.00	0.00
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)						62.01	0.00
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>								
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)						63.00	N
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
64.00	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. 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)						64.00	0.00 0.00 0.000000
		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: 14-4005

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

Worksheet S-2
Part I
Date/Time Prepared:
4/23/2018 11:33 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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		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	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.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					Y	Y	98.06	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)							106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.							107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					N		108.00	
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.								109.00
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.					N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Prepared: 4/23/2018 11:33 am		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00			
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.	Y	E	98		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:	271,495	0			118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	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						
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		HB0230		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part I Date/Time Prepared: 4/23/2018 11:33 am	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: SIGNATURE HEALTHCARE	Contractor's Name: WPS		Contractor's Number: 08201		141.00	
142.00	Street: 1450 W LONG LAKE RD, SUITE 340	PO Box:				142.00	
143.00	City: TROY	State: MI		Zip Code: 48098		143.00	
144.00 Are provider based physicians' costs included in Worksheet A?							
						1.00	144.00
						Y	
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.							
						1.00	145.00
						N	
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.							
						1.00	146.00
						N	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
						1.00	147.00
						N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
						1.00	148.00
						N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
						1.00	149.00
						N	
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)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
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	
Multi campus							
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							
						1.00	165.00
						N	
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.							
						1.00	167.00
						N	
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)							
						1.00	168.00
						0.00	
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)							
						1.00	168.01
						0.00	
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)							
						1.00	169.00
						0.00	
Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
						1.00	170.00
						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)							
						1.00	171.00
						N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet S-2 Part II Date/Time Prepared: 4/23/2018 11:33 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				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					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	02/21/2018	Y	02/21/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 4/23/2018 11:33 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 relieved 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.		Y		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?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		WATSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	SOUTHEAST REIMBURSEMENT GROUP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	205-783-1506		MI CHAEL.WATSON@SRGLLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Prepared: 4/23/2018 11:33 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.	CONSULTANT		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: 14-4005

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

Worksheet S-3
Part I
Date/Time Prepared:
4/23/2018 11:33 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	101	36,865	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)		101	36,865	0.00	0	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 CHILDRENS	35.00	60	21,900	0.00	0	12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		161	58,765	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	5	1,825			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		166			0	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: 14-4005

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

Worksheet S-3
Part I
Date/Time Prepared:
4/23/2018 11:33 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)	4,038	1,679	28,770			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,038	1,679	28,770			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 CHILDRENS	0	9,008	15,382			12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	4,038	10,687	44,152	0.00	356.27	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE			4	0.00	0.00	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	356.27	27.00
28.00 Observation Bed Days		0	0			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	0	0			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: 14-4005

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

Worksheet S-3
Part I
Date/Time Prepared:
4/23/2018 11:33 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	435	712	5,323	1.00
2.00 HMO and other (see instructions)			0	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 CHILDRENS						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	435	712	5,323	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				1	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4005

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

Worksheet A
Date/Time Prepared:
4/23/2018 11:33 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	0	0	5,076,944	5,076,944	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	540,621	540,621	2.00	
3.00	00300	OTHER CAP REL COSTS	794,408	794,408	-794,408	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	170,313	2,283,475	2,453,788	0	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	6,514,174	9,125,407	15,639,581	-5,578,602	10,060,979	5.00
7.00	00700	OPERATION OF PLANT	284,233	810,670	1,094,903	-2,873	1,092,030	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	148,082	148,082	8.00
9.00	00900	HOUSEKEEPING	390,672	555,709	946,381	-148,082	798,299	9.00
10.00	01000	DIETARY	698,028	983,800	1,681,828	-157,412	1,524,416	10.00
11.00	01100	CAFETERIA	0	0	0	141,077	141,077	11.00
13.00	01300	NURSING ADMINISTRATION	1,044,538	284,200	1,328,738	-2,726	1,326,012	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	482,660	225,100	707,760	0	707,760	16.00
17.00	01700	SOCIAL SERVICE	1,536,992	144,640	1,681,632	0	1,681,632	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,522,012	1,034,847	6,556,859	236,076	6,792,935	30.00
35.00	02400	CHILDRENS	3,105,446	321,745	3,427,191	60,480	3,487,671	35.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	261	261	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	182,509	182,509	0	182,509	60.00
69.00	06900	ELECTROCARDIOLOGY	0	33,840	33,840	0	33,840	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	996,685	996,685	0	996,685	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	525,677	130,228	655,905	0	655,905	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,274,745	17,907,263	38,182,008	-480,562	37,701,446	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	PATIENT SCHOOL	104,819	10,071	114,890	-86,167	28,723	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	0	0	0	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	0	0	0	525,066	525,066	194.02
194.03	07953	PATIENT TRANSPORTATION	0	0	0	41,663	41,663	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	20,379,564	17,917,334	38,296,898	0	38,296,898	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-4005

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

Worksheet A
Date/Time Prepared:
4/23/2018 11:33 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	-686,224	4,390,720	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	540,621	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,453,788	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-3,266,219	6,794,760	5.00
7.00	00700	OPERATION OF PLANT	0	1,092,030	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	148,082	8.00
9.00	00900	HOUSEKEEPING	0	798,299	9.00
10.00	01000	DIETARY	-530	1,523,886	10.00
11.00	01100	CAFETERIA	-11,779	129,298	11.00
13.00	01300	NURSING ADMINISTRATION	-43	1,325,969	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-89	707,671	16.00
17.00	01700	SOCIAL SERVICE	0	1,681,632	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-572,952	6,219,983	30.00
35.00	02400	CHILDRENS	-43,115	3,444,556	35.00
46.00	04600	OTHER LONG TERM CARE	0	261	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	182,509	60.00
69.00	06900	ELECTROCARDIOLOGY	0	33,840	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	996,685	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	PARTIAL HOSPITAL	-31,215	624,690	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,612,166	33,089,280	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	PATIENT SCHOOL	0	28,723	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	0	525,066	194.02
194.03	07953	PATIENT TRANSPORTATION	0	41,663	194.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,612,166	33,684,732	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTS & LEASES					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	4,373,119	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	172,354	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	O		0	4,545,473	
B - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,202	1.00
	O		0	6,202	
C - MEDICAL PROFESSIONAL FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	202,733	1.00
2.00	CHILDRENS	35.00	0	60,480	2.00
	O		0	263,213	
D - PATIENT TRANSPORTATION					
1.00	PATIENT TRANSPORTATION	194.03	38,111	3,552	1.00
	O		38,111	3,552	
E - CONTRACT LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8.00	0	148,082	1.00
	O		0	148,082	
F - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	131,759	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	139,723	2.00
	O		0	271,482	
G - PATIENT SCHOOL					
1.00	ADULTS & PEDIATRICS	30.00	78,614	7,553	1.00
	O		78,614	7,553	
H - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	58,553	82,524	1.00
	O		58,553	82,524	
I - BUSINESS DEVELOPMENT COSTS					
1.00	BUSINESS DEVELOPMENT	194.02	423,613	101,453	1.00
	O		423,613	101,453	
K - RTC COSTS					
1.00	OTHER LONG TERM CARE	46.00	239	22	1.00
	TOTALS		239	22	
500.00	Grand Total: Increases		599,130	5,429,556	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTS & LEASES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,512,639	10		1.00
2.00	OPERATION OF PLANT	7.00	0	2,873	10		2.00
3.00	DIETARY	10.00	0	16,335	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	2,726	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	10,900	0		5.00
	O			4,545,473			
B - INTEREST							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,202	11		1.00
	O			6,202			
C - MEDICAL PROFESSIONAL FEES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	263,213	0		1.00
2.00		0.00	0	0	0		2.00
	O			263,213			
D - PATIENT TRANSPORTATION							
1.00	ADULTS & PEDIATRICS	30.00	38,111	3,552	0		1.00
	O		38,111	3,552			
E - CONTRACT LAUNDRY							
1.00	HOUSEKEEPING	9.00	0	148,082	0		1.00
	O			148,082			
F - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	271,482	9		1.00
2.00		0.00	0	0	9		2.00
	O			271,482			
G - PATIENT SCHOOL							
1.00	PATIENT SCHOOL	194.00	78,614	7,553	0		1.00
	O		78,614	7,553			
H - CAFETERIA COSTS							
1.00	DIETARY	10.00	58,553	82,524	0		1.00
	O		58,553	82,524			
I - BUSINESS DEVELOPMENT COSTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	423,613	101,453	0		1.00
	O		423,613	101,453			
K - RTC COSTS							
1.00	ADULTS & PEDIATRICS	30.00	239	22	0		1.00
	TOTALS		239	22			
500.00	Grand Total: Decreases		599,130	5,429,556			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4005

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

Worksheet A-7
Part I
Date/Time Prepared:
4/23/2018 11:33 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	3.00
4.00	Building Improvements	4,906,864	0	0	2,027,202	4.00
5.00	Fixed Equipment	265,036	0	0	0	5.00
6.00	Movable Equipment	1,344,969	0	0	74,873	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	6,516,869	0	0	2,102,075	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	6,516,869	0	0	2,102,075	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	0	0			1.00
2.00	Land Improvements	0	0			2.00
3.00	Buildings and Fixtures	0	0			3.00
4.00	Building Improvements	2,879,662	0			4.00
5.00	Fixed Equipment	265,036	0			5.00
6.00	Movable Equipment	1,270,096	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	4,414,794	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	4,414,794	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4005

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

Worksheet A-7
Part II
Date/Time Prepared:
4/23/2018 11:33 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-4005

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

Worksheet A-7
Part III
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,144,698	0	3,144,698	0.712309	44,454	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,270,096	0	1,270,096	0.287691	17,954	2.00
3.00	Total (sum of lines 1-2)	4,414,794	0	4,414,794	1.000000	62,408	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	521,410	0	565,864	127,334	3,691,320	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	210,590	0	228,544	139,723	172,354	2.00
3.00	Total (sum of lines 1-2)	732,000	0	794,408	267,057	3,863,674	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	6,202	44,454	521,410	0	4,390,720	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	17,954	210,590	0	540,621	2.00
3.00	Total (sum of lines 1-2)	6,202	62,408	732,000	0	4,931,341	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4005

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

Worksheet A-8

Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-1,053		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)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)	B	-4,425		CAP REL COSTS-BLDG & FIXT	1.00	9	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,067,185				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	-737,175				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-11,779		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-89		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	B	-161,214		ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	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	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 RENTAL INCOME/COMMISSION	B	-12,770		ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-4005

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

Worksheet A-8

Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
34.00	PHYSICIAN COSTS	A	-53,712	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	CONTRIBUTIONS	A	-4,300	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	LOBBYING COSTS	A	-7,263	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PATIENT TRANSPORTATION	A	-15,415	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	PATIENT TRANSPORTATION	A	-43	NURSING ADMINISTRATION	13.00	0	37.01
37.02	PATIENT TRANSPORTATION	A	-15,243	ADULTS & PEDIATRICS	30.00	0	37.02
37.03	PATIENT TRANSPORTATION	A	-31,215	PARTIAL HOSPITAL	93.00	0	37.03
38.00	PENALTIES & FINES	A	-530	DIETARY	10.00	0	38.00
39.00	LEGAL FEES	A	-488,755	ADMINISTRATIVE & GENERAL	5.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,612,166				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: 14-4005

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

Worksheet A-8-1

Date/Time Prepared:
4/23/2018 11:33 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE COSTS	1,115,498	1,168,410 1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY COSTS	2,894	5,358 2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	OWNERSHIP COSTS	431,534	1,113,333 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,549,926	2,287,101 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.

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

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

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

6.00	B	0.00	SIGNATURE HLTHC	100.00	6.00
7.00	D	0.00	KEBOK	100.00	7.00
8.00	D	0.00	IL MENTAL HLTH	100.00	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: 14-4005

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

Worksheet A-8-1

Date/Time Prepared:
4/23/2018 11:33 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	-52,912	0		1.00
2.00	-2,464	0		2.00
3.00	-681,799	10		3.00
4.00	0	0		4.00
5.00	-737,175			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	HOSPITAL MGMT		6.00
7.00	COMPUTER SVCS		7.00
8.00	REIT		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: 14-4005

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

Worksheet A-8-2

Date/Time Prepared:
4/23/2018 11:33 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	AGGREGATE-ADMINISTRATIVE & GENERAL	2,489,180	2,457,097	32,083	154,100	308	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	580,824	535,399	45,425	154,100	312	2.00
3.00	35.00	AGGREGATE-CHILDRENS	75,120	14,640	60,480	154,100	432	3.00
4.00	0.00		0	0	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			3,145,124	3,007,136	137,988		1,052	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	AGGREGATE-ADMINISTRATIVE & GENERAL	22,819	1,141	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	23,115	1,156	0	0	0	2.00
3.00	35.00	AGGREGATE-CHILDRENS	32,005	1,600	0	0	0	3.00
4.00	0.00		0	0	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			77,939	3,897	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	AGGREGATE-ADMINISTRATIVE & GENERAL	0	22,819	9,264	2,466,361	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	23,115	22,310	557,709	2.00
3.00	35.00	AGGREGATE-CHILDRENS	0	32,005	28,475	43,115	3.00
4.00	0.00		0	0	0	0	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	77,939	60,049	3,067,185	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4005

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

Worksheet B
Part I
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,390,720	4,390,720			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	540,621		540,621		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,453,788	15,744	1,939	2,471,471	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,794,760	419,171	51,612	744,840	5.00
7.00 00700	OPERATION OF PLANT	1,092,030	259,431	31,943	34,760	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	148,082	0	0	0	8.00
9.00 00900	HOUSEKEEPING	798,299	21,904	2,697	47,777	9.00
10.00 01000	DIETARY	1,523,886	114,500	14,098	78,204	10.00
11.00 01100	CAFETERIA	129,298	91,600	11,279	7,161	11.00
13.00 01300	NURSING ADMINISTRATION	1,325,969	52,023	6,405	127,741	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	707,671	23,896	2,942	59,026	16.00
17.00 01700	SOCIAL SERVICE	1,681,632	0	0	187,965	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,219,983	2,559,025	315,088	680,233	30.00
35.00 02400	CHILDRENS	3,444,556	533,423	65,679	379,777	35.00
46.00 04600	OTHER LONG TERM CARE	261	0	0	29	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	182,509	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	33,840	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	996,685	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	PARTIAL HOSPITAL	624,690	271,627	33,445	64,287	93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	33,089,280	4,362,344	537,127	2,411,800	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	21,220	2,613	0	192.00
194.00 07950	PATIENT SCHOOL	28,723	7,156	881	3,205	194.00
194.01 07951	NON REIMBURSABLE MEALS	0	0	0	0	194.01
194.02 07952	BUSINESS DEVELOPMENT	525,066	0	0	51,805	194.02
194.03 07953	PATIENT TRANSPORTATION	41,663	0	0	4,661	194.03
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	33,684,732	4,390,720	540,621	2,471,471	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4005

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

Worksheet B
Part I
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,010,383				5.00
7.00	00700	OPERATION OF PLANT	442,466	1,860,630			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,201	0	194,283		8.00
9.00	00900	HOUSEKEEPING	271,650	11,026	0	1,153,353	9.00
10.00	01000	DIETARY	539,973	57,636	0	35,940	10.00
11.00	01100	CAFETERIA	74,673	46,109	0	28,752	11.00
13.00	01300	NURSING ADMINISTRATION	471,786	26,187	0	16,329	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	247,582	12,028	0	7,500	16.00
17.00	01700	SOCIAL SERVICE	583,312	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,049,594	1,288,126	126,585	803,234	30.00
35.00	02400	CHILDRENS	1,380,107	268,507	67,680	167,432	35.00
46.00	04600	OTHER LONG TERM CARE	90	0	18	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	56,943	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	10,558	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,965	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	310,142	136,728	0	85,259	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,796,042	1,846,347	194,283	1,144,446	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,436	10,681	0	6,661	192.00
194.00	07950	PATIENT SCHOOL	12,469	3,602	0	2,246	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	0	0	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	179,983	0	0	0	194.02
194.03	07953	PATIENT TRANSPORTATION	14,453	0	0	0	194.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,010,383	1,860,630	194,283	1,153,353	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4005

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

Worksheet B
Part I
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	502,689					11.00
13.00	01300	24,147	2,050,587				13.00
16.00	01600	19,756	84,283	1,164,684			16.00
17.00	01700	76,830	342,063	0	2,871,802		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	204,149	908,055	591,387	1,871,133	20,032,898	30.00
35.00	02400	136,099	610,008	375,181	1,000,409	9,186,093	35.00
46.00	04600	0	0	58	260	913	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	16,374	0	255,826	60.00
69.00	06900	0	0	3,036	0	47,434	69.00
73.00	07300	0	0	89,420	0	1,397,070	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	24,147	106,178	89,228	0	1,745,731	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		485,128	2,050,587	1,164,684	2,871,802	32,665,965	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	48,611	192.00
194.00	07950	2,195	0	0	0	60,477	194.00
194.01	07951	0	0	0	0	76,682	194.01
194.02	07952	13,171	0	0	0	770,025	194.02
194.03	07953	2,195	0	0	0	62,972	194.03
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		502,689	2,050,587	1,164,684	2,871,802	33,684,732	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-4005

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

Worksheet B
Part I
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
35.00	02400	CHILDRENS	0	35.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
93.00	04950	PARTIAL HOSPITAL	0	93.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	PATIENT SCHOOL	0	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	0	194.02
194.03	07953	PATIENT TRANSPORTATION	0	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4005

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

Worksheet B
Part II
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	2.00			
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	15,744	1,939	17,683	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	68,402	419,171	51,612	539,185	5.00
7.00 00700	OPERATION OF PLANT	0	259,431	31,943	291,374	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	21,904	2,697	24,601	9.00
10.00 01000	DIETARY	0	114,500	14,098	128,598	10.00
11.00 01100	CAFETERIA	0	91,600	11,279	102,879	11.00
13.00 01300	NURSING ADMINISTRATION	0	52,023	6,405	58,428	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	23,896	2,942	26,838	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	2,559,025	315,088	2,874,113	30.00
35.00 02400	CHILDRENS	0	533,423	65,679	599,102	35.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	PARTIAL HOSPITAL	0	271,627	33,445	305,072	93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	68,402	4,362,344	537,127	4,967,873	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	21,220	2,613	23,833	192.00
194.00 07950	PATIENT SCHOOL	0	7,156	881	8,037	194.00
194.01 07951	NON REIMBURSABLE MEALS	0	0	0	0	194.01
194.02 07952	BUSINESS DEVELOPMENT	0	0	0	0	194.02
194.03 07953	PATIENT TRANSPORTATION	0	0	0	0	194.03
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	68,402	4,390,720	540,621	4,999,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4005

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

Worksheet B
Part II
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	544,514					5.00
7.00	00700	30,076	321,699				7.00
8.00	00800	3,141	0	3,141			8.00
9.00	00900	18,465	1,906	0	45,314		9.00
10.00	01000	36,704	9,965	0	1,412	177,239	10.00
11.00	01100	5,076	7,972	0	1,130	8,532	11.00
13.00	01300	32,069	4,528	0	642	0	13.00
16.00	01600	16,829	2,080	0	295	0	16.00
17.00	01700	39,650	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	207,308	222,714	2,047	31,557	106,176	30.00
35.00	02400	93,812	46,424	1,094	6,578	56,767	35.00
46.00	04600	6	0	0	0	15	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	3,871	0	0	0	0	60.00
69.00	06900	718	0	0	0	0	69.00
73.00	07300	21,138	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	21,082	23,640	0	3,350	0	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
SUBTOTALS (SUM OF LINES 1 through 117)		529,945	319,229	3,141	44,964	171,490	
NONREIMBURSABLE COST CENTERS							
192.00	19200	505	1,847	0	262	0	192.00
194.00	07950	848	623	0	88	0	194.00
194.01	07951	0	0	0	0	5,749	194.01
194.02	07952	12,234	0	0	0	0	194.02
194.03	07953	982	0	0	0	0	194.03
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		544,514	321,699	3,141	45,314	177,239	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4005

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
		11.00	13.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	125,640					11.00
13.00	01300	6,035	102,616				13.00
16.00	01600	4,938	4,218	55,620			16.00
17.00	01700	19,203	17,118	0	77,316		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	51,023	45,441	28,224	50,376	3,623,846	30.00
35.00	02400	34,016	30,526	17,929	26,933	915,898	35.00
46.00	04600	0	0	3	7	31	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
60.00	06000	0	0	782	0	4,653	60.00
69.00	06900	0	0	145	0	863	69.00
73.00	07300	0	0	4,273	0	25,411	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	6,035	5,313	4,264	0	369,216	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		121,250	102,616	55,620	77,316	4,939,918	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	26,447	192.00
194.00	07950	549	0	0	0	10,168	194.00
194.01	07951	0	0	0	0	5,749	194.01
194.02	07952	3,292	0	0	0	15,897	194.02
194.03	07953	549	0	0	0	1,564	194.03
200.00						0	200.00
201.00		0	0	0	0	0	201.00
202.00		125,640	102,616	55,620	77,316	4,999,743	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-4005

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
35.00	02400	CHILDRENS	0	35.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
OUTPATIENT SERVICE COST CENTERS				
93.00	04950	PARTIAL HOSPITAL	0	93.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	PATIENT SCHOOL	0	194.00
194.01	07951	NON REIMBURSABLE MEALS	0	194.01
194.02	07952	BUSINESS DEVELOPMENT	0	194.02
194.03	07953	PATIENT TRANSPORTATION	0	194.03
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4005

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

Worksheet B-1
Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	70,558				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		70,558			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	253	253	20,209,251		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	6,736	6,736	6,090,561	-8,010,383	5.00
7.00 00700	OPERATION OF PLANT	4,169	4,169	284,233	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	352	352	390,672	0	9.00
10.00 01000	DIETARY	1,840	1,840	639,475	0	10.00
11.00 01100	CAFETERIA	1,472	1,472	58,553	0	11.00
13.00 01300	NURSING ADMINISTRATION	836	836	1,044,538	0	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	384	384	482,660	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	1,536,992	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	41,123	41,123	5,562,276	0	30.00
35.00 02400	CHILDRENS	8,572	8,572	3,105,446	0	35.00
46.00 04600	OTHER LONG TERM CARE	0	0	239	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	0	60.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
93.00 04950	PARTIAL HOSPITAL	4,365	4,365	525,677	0	93.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	70,102	70,102	19,721,322	-8,010,383	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	341	341	0	0	192.00
194.00 07950	PATIENT SCHOOL	115	115	26,205	0	194.00
194.01 07951	NON REIMBURSABLE MEALS	0	0	0	0	194.01
194.02 07952	BUSINESS DEVELOPMENT	0	0	423,613	0	194.02
194.03 07953	PATIENT TRANSPORTATION	0	0	38,111	0	194.03
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)	4,390,720	540,621	2,471,471		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	62.228521	7.662079	0.122294		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			17,683		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000875		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: 14-4005

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	59,400				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,156			8.00
9.00	00900	HOUSEKEEPING	352	0	59,048		9.00
10.00	01000	DIETARY	1,840	0	1,840	144,077	10.00
11.00	01100	CAFETERIA	1,472	0	1,472	6,936	229
13.00	01300	NURSING ADMINISTRATION	836	0	836	0	11
16.00	01600	MEDICAL RECORDS & LIBRARY	384	0	384	0	9
17.00	01700	SOCIAL SERVICE	0	0	0	0	35
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,123	28,770	41,123	86,310	93
35.00	02400	CHILDRENS	8,572	15,382	8,572	46,146	62
46.00	04600	OTHER LONG TERM CARE	0	4	0	12	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	4,365	0	4,365	0	11
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	58,944	44,156	58,592	139,404	221
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	341	0	341	0	0
194.00	07950	PATIENT SCHOOL	115	0	115	0	1
194.01	07951	NON REIMBURSABLE MEALS	0	0	0	4,673	0
194.02	07952	BUSINESS DEVELOPMENT	0	0	0	0	6
194.03	07953	PATIENT TRANSPORTATION	0	0	0	0	1
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	1,860,630	194,283	1,153,353	2,364,237	502,689
203.00		Unit cost multiplier (Wkst. B, Part I)	31.323737	4.399923	19.532465	16.409538	2,195.148472
204.00		Cost to be allocated (per Wkst. B, Part II)	321,699	3,141	45,314	177,239	125,640
205.00		Unit cost multiplier (Wkst. B, Part II)	5.415808	0.071134	0.767410	1.230169	548.646288
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-4005

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300	436,719			13.00
16.00	01600	17,950	81,132,025		16.00
17.00	01700	72,850	0	44,156	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	193,391	41,194,930	28,770	30.00
35.00	02400	129,915	26,135,905	15,382	35.00
46.00	04600	0	4,025	4	46.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	0	0	0	54.00
60.00	06000	0	1,140,669	0	60.00
69.00	06900	0	211,498	0	69.00
73.00	07300	0	6,229,210	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	22,613	6,215,788	0	93.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		436,719	81,132,025	44,156	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	0	0	0	192.00
194.00	07950	0	0	0	194.00
194.01	07951	0	0	0	194.01
194.02	07952	0	0	0	194.02
194.03	07953	0	0	0	194.03
200.00					200.00
201.00					201.00
202.00		2,050,587	1,164,684	2,871,802	202.00
203.00		4.695438	0.014355	65.037639	203.00
204.00		102,616	55,620	77,316	204.00
205.00		0.234970	0.000686	1.750974	205.00
206.00					206.00
207.00					207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4005

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

Worksheet C
Part I
Date/Time Prepared:
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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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	20,032,898		20,032,898	22,310	20,055,208	30.00
35.00	02400 CHILDRENS	9,186,093		9,186,093	28,475	9,214,568	35.00
46.00	04600 OTHER LONG TERM CARE	913		913	0	913	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	06000 LABORATORY	255,826		255,826	0	255,826	60.00
69.00	06900 ELECTROCARDIOLOGY	47,434		47,434	0	47,434	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,397,070		1,397,070	0	1,397,070	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950 PARTIAL HOSPITAL	1,745,731		1,745,731	0	1,745,731	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	32,665,965	0	32,665,965	50,785	32,716,750	200.00
201.00	Less Observation Beds	0		0		0	201.00
202.00	Total (see instructions)	32,665,965	0	32,665,965	50,785	32,716,750	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4005

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII		Hospital			PPS		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,194,930		41,194,930		30.00
35.00	02400	CHILDRENS	26,135,905		26,135,905		35.00
46.00	04600	OTHER LONG TERM CARE	4,025		4,025		46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	1,140,669	0	1,140,669	0.224277	60.00
69.00	06900	ELECTROCARDIOLOGY	211,498	0	211,498	0.224276	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,229,210	0	6,229,210	0.224277	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	0	6,215,788	6,215,788	0.280854	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	74,916,237	6,215,788	81,132,025		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	74,916,237	6,215,788	81,132,025		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 4/23/2018 11:33 am
		Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
35.00	02400	CHILDRENS		35.00
46.00	04600	OTHER LONG TERM CARE		46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.224277	60.00
69.00	06900	ELECTROCARDIOLOGY	0.224276	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224277	73.00
OUTPATIENT SERVICE COST CENTERS				
93.00	04950	PARTIAL HOSPITAL	0.280854	93.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet C Part I Date/Time Prepared: 4/23/2018 11:33 am		
		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,032,898		20,032,898	22,310	20,055,208	30.00
35.00	02400	CHILDRENS	9,186,093		9,186,093	28,475	9,214,568	35.00
46.00	04600	OTHER LONG TERM CARE	913		913	0	913	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		0	0	0	54.00
60.00	06000	LABORATORY	255,826		255,826	0	255,826	60.00
69.00	06900	ELECTROCARDIOLOGY	47,434		47,434	0	47,434	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,397,070		1,397,070	0	1,397,070	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	1,745,731		1,745,731	0	1,745,731	93.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	32,665,965	0	32,665,965	50,785	32,716,750	200.00
201.00		Less Observation Beds	0		0		0	201.00
202.00		Total (see instructions)	32,665,965	0	32,665,965	50,785	32,716,750	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-4005

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

Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		Title XIX			Hospital	Cost	
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,194,930		41,194,930		30.00
35.00	02400	CHILDRENS	26,135,905		26,135,905		35.00
46.00	04600	OTHER LONG TERM CARE	4,025		4,025		46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	1,140,669	0	1,140,669	0.224277	60.00
69.00	06900	ELECTROCARDIOLOGY	211,498	0	211,498	0.224276	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,229,210	0	6,229,210	0.224277	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	0	6,215,788	6,215,788	0.280854	93.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	74,916,237	6,215,788	81,132,025		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	74,916,237	6,215,788	81,132,025		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 4/23/2018 11:33 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
35.00	02400 CHILDRENS			35.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
93.00	04950 PARTIAL HOSPITAL	0.000000		93.00
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: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part I Date/Time Prepared: 4/23/2018 11:33 am	
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)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	3,623,846	0	3,623,846	28,770	125.96	30.00
35.00	CHILDRENS	915,898		915,898	15,382	59.54	35.00
200.00	Total (lines 30 through 199)	4,539,744		4,539,744	44,152		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,038	508,626				
35.00	CHILDRENS	0	0				
200.00	Total (lines 30 through 199)	4,038	508,626				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet D Part II Date/Time Prepared: 4/23/2018 11:33 am	
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	
Title XVIII Hospital PPS							
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0.000000	0	0 54.00
60.00	06000	LABORATORY	4,653	1,140,669	0.004079	0	0 60.00
69.00	06900	ELECTROCARDIOLOGY	863	211,498	0.004080	0	0 69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,411	6,229,210	0.004079	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	369,216	6,215,788	0.059400	0	0 93.00
200.00		Total (lines 50 through 199)	400,143	13,797,165		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part III Date/Time Prepared: 4/23/2018 11:33 am
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Cost Center Description	Title XVIII		Hospital		PPS
	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	30.00
35.00	02400	CHILDRENS	0	0	0	35.00
200.00		Total (lines 30 through 199)	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

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	28,770	0.00	4,038	30.00
35.00	02400	CHILDRENS	0	15,382	0.00	0	35.00
200.00		Total (lines 30 through 199)	0	44,152		4,038	200.00

Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)

INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0			30.00
35.00	02400	CHILDRENS	0			35.00
200.00		Total (lines 30 through 199)	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-4005

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

Worksheet D
Part IV
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		Title XVIII			Hospital		PPS	
		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								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	0	0	0	0	0	93.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Prepared: 4/23/2018 11:33 am
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Cost Center Description	Title XVIII			Hospital	PPS		
	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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	54.00
60.00	06000	LABORATORY	0	0	1,140,669	0.000000	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	211,498	0.000000	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	6,229,210	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950	PARTIAL HOSPITAL	0	0	6,215,788	0.000000	93.00
200.00		Total (lines 50 through 199)	0	0	13,797,165		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-4005

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

Worksheet D
Part IV
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		Title XVIII			Hospital		PPS
		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							
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
93.00	04950 PARTIAL HOSPITAL	0.000000	0	0	0	0	93.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 4/23/2018 11:33 am
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Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.224277	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.224276	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224277	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	0.280854	0	0	520,208	0	93.00
200.00		Subtotal (see instructions)		0	0	520,208	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	520,208	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 4/23/2018 11:33 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	PARTIAL HOSPITAL	0	146,102	93.00
200.00		Subtotal (see instructions)	0	146,102	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	146,102	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 4/23/2018 11:33 am
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Title XIX		Hospital		Cost				
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCI LLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.224277	0	0	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0.224276	0	0	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.224277	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
93.00	04950	PARTIAL HOSPITAL	0.280854	0	0	440,336	0	93.00
200.00		Subtotal (see instructions)		0	0	440,336	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		0	0	440,336	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Prepared: 4/23/2018 11:33 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs				
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCI LLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950	PARTIAL HOSPITAL	0	123,670	93.00
200.00		Subtotal (see instructions)	0	123,670	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	123,670	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 4/23/2018 11:33 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		28,770	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		28,770	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)		28,770	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)		4,038	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)		20,055,208	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)		20,055,208	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)		20,055,208	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)		697.09	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,814,849	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)		2,814,849	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 4/23/2018 11:33 am	
Cost Center Description			Title XVIII	Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	CHILDRENS	9,214,568	15,382	599.05	0	0 47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,758,552	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)				508,626	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				508,626	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				2,249,926	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: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 4/23/2018 11:33 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,623,846	20,055,208	0.180694	0	0	90.00
91.00	Nursing School cost	0	20,055,208	0.000000	0	0	91.00
92.00	Allied health cost	0	20,055,208	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,055,208	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 4/23/2018 11:33 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			28,770 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			28,770 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)			28,770 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)			1,679 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)			20,032,898 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)			20,032,898 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)			20,032,898 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)			696.31 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,169,104 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)			1,169,104 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 4/23/2018 11:33 am	
Cost Center Description			Title XIX		Hospital	Cost
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	CHILDRENS					47.00
	9,186,093	15,382	597.20	9,008	5,379,578	
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,417,708
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00	Total Program excludable cost (sum of lines 50 and 51)					0
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-4005		Period: From 01/01/2017 To 12/31/2017		Worksheet D-1 Date/Time Prepared: 4/23/2018 11:33 am	
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	3,623,846	20,032,898	0.180895	0	0	90.00
91.00	Nursing School cost	0	20,032,898	0.000000	0	0	91.00
92.00	Allied health cost	0	20,032,898	0.000000	0	0	92.00
93.00	All other Medical Education	0	20,032,898	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 4/23/2018 11:33 am	
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		6,786,259		30.00
35.00	02400 CHILDRENS		0		35.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.224277	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0.224276	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.224277	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950 PARTIAL HOSPITAL	0.280854	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet D-3 Date/Time Prepared: 4/23/2018 11:33 am	
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		2,238,567		30.00
35.00	02400 CHILDRENS		11,917,584		35.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000 LABORATORY	0.224277	0	0	60.00
69.00	06900 ELECTROCARDIOLOGY	0.224276	0	0	69.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.224277	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
93.00	04950 PARTIAL HOSPITAL	0.280854	0	0	93.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 4/23/2018 11:33 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		169,393	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		520,208	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)		520,208	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 charge basis 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)		520,208	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		520,208	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		169,393	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)		34,723	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)		134,670	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)		134,670	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		134,670	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)		34,641	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		22,517	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		26,768	36.00
37.00	Subtotal (see instructions)		157,187	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		157,187	40.00
40.01	Sequestration adjustment (see instructions)		3,144	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		131,976	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		22,067	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: 14-4005

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

Worksheet E-1
Part I
Date/Time Prepared:
4/23/2018 11:33 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		2,798,135		131,976		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	01/02/2018	190,800		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)		190,800		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,988,935		131,976		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		69,833		22,067		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		3,058,768		154,043		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		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part II Date/Time Prepared: 4/23/2018 11:33 am
		Title XVIII	Hospital	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		3,371,107	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	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	6.00
7.00	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	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		78.821918	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		3,371,107	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		3,371,107	16.00
17.00	Primary payer payments		16,865	17.00
18.00	Subtotal (line 16 less line 17).		3,354,242	18.00
19.00	Deductibles		321,020	19.00
20.00	Subtotal (line 18 minus line 19)		3,033,222	20.00
21.00	Coinsurance		102,606	21.00
22.00	Subtotal (line 20 minus line 21)		2,930,616	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		293,194	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		190,576	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		144,854	25.00
26.00	Subtotal (sum of lines 22 and 24)		3,121,192	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		3,121,192	31.00
31.01	Sequestration adjustment (see instructions)		62,424	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		2,988,935	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		69,833	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-4005	Period: From 01/01/2017 To 12/31/2017	Worksheet E-3 Part VII Date/Time Prepared: 4/23/2018 11:33 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		6,417,708		1.00
2.00	Medical and other services			123,670	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6,417,708	123,670	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,417,708	123,670	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		14,156,151		8.00
9.00	Ancillary service charges		0	440,336	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		14,156,151	440,336	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		14,156,151	440,336	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		7,738,443	316,666	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		6,417,708	123,670	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		6,417,708	123,670	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,417,708	123,670	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,417,708	123,670	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		6,417,708	123,670	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		6,417,708	123,670	40.00
41.00	Interim payments		6,417,708	123,670	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

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

Provider CCN: 14-4005

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

Worksheet G
Date/Time Prepared:
4/23/2018 11:33 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	6,552,475	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,827,803	0	0	0	4.00
5.00	Other receivable	4,093,282	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	150,914	0	0	0	7.00
8.00	Prepaid expenses	207,341	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	16,831,815	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	346,813	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	346,813	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,223,839	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,223,839	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,402,467	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,069,586	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	808,593	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,878,179	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	618,052	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	618,052	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	2,496,231	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	15,906,236				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)	15,906,236	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,402,467	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-4005

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

Worksheet G-1

Date/Time Prepared:
4/23/2018 11:33 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		16,398,944		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		4,136,850			2.00
3.00	Total (sum of line 1 and line 2)		20,535,794		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		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)		20,535,794		0	11.00
12.00	DISTRIBUTION	4,629,558		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		4,629,558		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,906,236		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	DISTRIBUTION		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: 14-4005

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/23/2018 11:33 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	41,194,930		41,194,930	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	4,025		4,025	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	41,198,955		41,198,955	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				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	CHILDRENS	26,135,905		26,135,905	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	26,135,905		26,135,905	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	67,334,860		67,334,860	17.00
18.00	Ancillary services	7,581,377		7,581,377	18.00
19.00	Outpatient services	0	6,215,788	6,215,788	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	SNAP REVENUE	2,513,403	0	2,513,403	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	77,429,640	6,215,788	83,645,428	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,296,898		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)		38,296,898		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-4005

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

Worksheet G-3

Date/Time Prepared:
4/23/2018 11:33 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	83,645,428	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,185,846	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,459,582	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,296,898	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,162,684	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	1,053	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	4,425	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	11,779	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	89	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	12,770	22.00
23.00	Governmental appropriations	0	23.00
24.00	FINANCE CHARGES	161,214	24.00
24.01	PROVIDER TAX	782,836	24.01
25.00	Total other income (sum of lines 6-24)	974,166	25.00
26.00	Total (line 5 plus line 25)	4,136,850	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,136,850	29.00