

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: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 11:19 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/28/2018	Time: 11:19 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ 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. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE ST. JOSEPH MEDICAL CENTER (14-0007) for the cost reporting period beginning 01/01/2018 and ending 06/30/2018 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) DEBORAH SCHIMEROWSKI
Officer or Administrator of Provider(s)

REGIONAL CFO
Title

(Dated when report is electronically signed.)
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	690,369	67,461	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	-62,190	57		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	628,179	67,518	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: 14-0007		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 4:11 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 333 NORTH MADISON STREET			PO Box:				1.00	
2.00	City: JOLIET			State: IL		Zip Code: 60435		County: KANE	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			PRESENCE ST. JOSEPH MEDICAL CENTER	140007	20994	1	07/01/1966	N P O
4.00	Subprovider - IPF								
5.00	Subprovider - IRF			SJMC PHYSICAL MED & REHAB	14T007	20994	5	09/07/1987	N P O
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2018	06/30/2018	20.00
21.00	Type of Control (see instructions)						1		21.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			5,498	1,196	0	0	1,708	467
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 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.			209	112	0	0	0	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 4:11 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.		0			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.					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)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
			Y/N	Y/N		
			1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N		40.00
			V	XVIII	XIX	
			1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)			23.00	1	60.01
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	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: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-2
Part I
Date/Time Prepared:
11/28/2018 4:11 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.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00

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Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-2
Part I
Date/Time Prepared:
11/28/2018 4:11 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			
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
	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.		N			70.00		
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00	
	Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	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. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical	Occupational	Speech
		1.00	2.00	3.00
				Respiratory
				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: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 4:11 am	
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	3,687,948	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H082	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0007		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 4:11 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: PRESENCE HEALTH		Contractor's Name: NGS		Contractor's Number: 00450				141.00	
142.00	Street: 200 SOUTH WACKER DRIVE		PO Box:						142.00	
143.00	City: CHICAGO		State: IL		Zip Code: 60606				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital			N	N	N	N			155.00
156.00	Subprovider - IPF			N	N	N	N			156.00
157.00	Subprovider - IRF			N	N	N	N			157.00
158.00	SUBPROVIDER									158.00
159.00	SNF			N	N	N	N			159.00
160.00	HOME HEALTH AGENCY			N	N	N	N			160.00
161.00	CMHC				N	N	N			161.00
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00			166.00
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						Beginning	Ending			
						1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						01/01/2018	06/30/2018	170.00	
						1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 4:11 am
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/05/2018	Y 11/05/2018
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 4:11 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ANNE	LITTLE	41.00
42.00	Enter the employer/company name of the cost report preparer.	PRESENCE HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/813-3721	ANNE.LITTLE@PRESENCEHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-2
Part II
Date/Time Prepared:
11/28/2018 4:11 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.	REG DIRECTOR, REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 4:11 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	376	68,056	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)		376	68,056	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	34	6,154	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	18	3,258	0.00	0	11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		428	77,468	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	41	7,421		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						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)		469			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)		4	724			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: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 4:11 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)	14,778	2,023	32,087			1.00
2.00	HMO and other (see instructions)	4,109	6,099				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	367	156				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	14,778	2,023	32,087			7.00
8.00	INTENSIVE CARE UNIT	1,149	90	3,001			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	995	2	1,635			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		638	1,802			13.00
14.00	Total (see instructions)	16,922	2,753	38,525	3.67	1,450.29	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	5,287	165	6,535	0.00	59.96	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	204			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)				3.67	1,510.25	27.00
28.00	Observation Bed Days		371	7,134			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	17	184			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			172			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: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 4:11 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,744	709	9,452	1.00
2.00 HMO and other (see instructions)			903	1,432		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				14		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,744	709	9,452	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	449	16	575	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-3
Part II
Date/Time Prepared:
11/28/2018 4:11 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	56,035,334	-197,734	55,837,600	1,570,660.00	35.55 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	28,643	28,643	1,040.00	27.54 7.00
7.01	Contracted interns and residents (in an approved programs)		0	100,517	100,517	2,170.00	46.32 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		2,713,944	0	2,713,944	80,318.00	33.79 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		8,479,775	0	8,479,775	200,996.00	42.19 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		341,209	0	341,209	2,535.00	134.60 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		15,051,720	0	15,051,720	390,163.00	38.58 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		14,331,316	0	14,331,316		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		760,396	0	760,396		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		3,388,306	0	3,388,306		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-34,639	34,639	0	0.00	0.00 26.00
27.00	Administrative & General	5.00	3,774,785	-63,282	3,711,503	88,347.00	42.01 27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-3
Part II
Date/Time Prepared:
11/28/2018 4:11 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		4,752,622	0	4,752,622	25,634.00	185.40	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,460,976	0	1,460,976	52,381.00	27.89	30.00
31.00	Laundry & Linen Service	8.00	81,605	0	81,605	5,377.00	15.18	31.00
32.00	Housekeeping	9.00	1,209,691	0	1,209,691	79,945.00	15.13	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,220,977	-602,928	618,049	40,661.00	15.20	34.00
35.00	Dietary under contract (see instructions)		721,256	0	721,256	14,569.00	49.51	35.00
36.00	Cafeteria	11.00	0	602,928	602,928	40,053.00	15.05	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,808,135	0	1,808,135	41,449.00	43.62	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,933,511	0	1,933,511	44,252.00	43.69	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-3
Part III
Date/Time Prepared:
11/28/2018 4:11 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	61,509,212	-326,894	61,182,318	1,607,653.00	38.06	1.00
2.00	Excluded area salaries (see instructions)	2,713,944	0	2,713,944	80,318.00	33.79	2.00
3.00	Subtotal salaries (line 1 minus line 2)	58,795,268	-326,894	58,468,374	1,527,335.00	38.28	3.00
4.00	Subtotal other wages & related costs (see inst.)	23,872,704	0	23,872,704	593,694.00	40.21	4.00
5.00	Subtotal wage-related costs (see inst.)	17,719,622	0	17,719,622	0.00	30.31	5.00
6.00	Total (sum of lines 3 thru 5)	100,387,594	-326,894	100,060,700	2,121,029.00	47.18	6.00
7.00	Total overhead cost (see instructions)	16,928,919	-28,643	16,900,276	432,668.00	39.06	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2018 4:11 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		2,133,436	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		2,440,093	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		5,277,992	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		124,970	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		31,768	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		173,034	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		623,957	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		4,074,950	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		54,848	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		156,664	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		15,091,712	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet S-3
Part V
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	8,479,775	15,091,712	1.00
2.00	Hospital	8,479,775	15,091,712	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet S-5

Date/Time Prepared:
11/28/2018 4:11 am

		Outpatient		Training		Home			
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD		
		1.00	2.00	3.00	4.00	5.00	6.00		
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00	
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00	
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00	
4.00	CAPD exchanges per day				0.00		0.00	4.00	
5.00	Number of days in year dialysis furnished	0	0					5.00	
6.00	Number of stations	0	0	0	0			6.00	
7.00	Treatment capacity per day per station	0	0					7.00	
8.00	Utilization (see instructions)	0.00	0.00					8.00	
9.00	Average times dialyzers re-used	0.00	0.00					9.00	
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00	
							Y/N		
							1.00		
ESRD PPS									
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						N	10.01	
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02	
						Prior to 1/1	After 12/31		
						1.00	2.00		
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	0	10.03
TRANSPLANT INFORMATION									
11.00	Number of patients on transplant list						0	11.00	
12.00	Number of patients transplanted during the cost reporting period						0	12.00	
EPOETIN									
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.							13.00	
14.00	Epoetin amount from Worksheet A for Home Dialysis program							14.00	
15.00	Number of EPO units furnished relating to the renal dialysis department							15.00	
16.00	Number of EPO units furnished relating to the home dialysis department							16.00	
ARANESP									
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.							17.00	
18.00	ARANESP amount from Worksheet A for Home Dialysis program							18.00	
19.00	Number of ARANESP units furnished relating to the renal dialysis department							19.00	
20.00	Number of ARANESP units furnished relating to the home dialysis department							20.00	
						MCP	INITIAL METHOD		
						1.00	2.00		
PHYSICIAN PAYMENT METHOD									
21.00	Enter "X" if method(s) is applicable							21.00	
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.			
		1.00	2.00	3.00	4.00	5.00			
ESAs									
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)		0	0	0	0	22.00		

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet S-5

Date/Time Prepared:
11/28/2018 4:11 am

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/28/2018 4:11 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.179670 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	13,601,443		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	203,069,134		6.00
7.00	Medicaid cost (line 1 times line 6)	36,485,431		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	22,883,988		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP	0		9.00
10.00	Stand-alone CHIP charges	0		10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	22,883,988		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	17,122,791	1,435,679	18,558,470 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,076,452	1,435,679	4,512,131 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	3,076,452	1,435,679	4,512,131 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,453,678		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	520,878		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	801,351		27.01
28.00	Non-Medicare bad debt expense (see instructions)	652,327		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	397,677		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,909,808		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	27,793,796		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A

Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (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		9,213	9,213	3,921,787	3,931,000	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	8,287,410	8,287,410	2.00
3.00	00300	OTHER CAP REL COSTS		88,078	88,078	-88,078	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-34,639	-866,507	-901,146	900,281	-865	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,774,785	45,219,731	48,994,516	-5,323,275	43,671,241	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,460,976	6,809,683	8,270,659	-1,081,170	7,189,489	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	81,605	473,044	554,649	-95	554,554	8.00
9.00	00900	HOUSEKEEPING	1,209,691	1,122,449	2,332,140	-33,879	2,298,261	9.00
10.00	01000	DIETARY	1,220,977	2,113,792	3,334,769	-1,616,732	1,718,037	10.00
11.00	01100	CAFETERIA	0	0	0	1,588,618	1,588,618	11.00
13.00	01300	NURSING ADMINISTRATION	1,808,135	946,069	2,754,204	-152,610	2,601,594	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-263,585	-263,585	-5,455	-269,040	14.00
15.00	01500	PHARMACY	1,933,511	9,170,819	11,104,330	-8,553,063	2,551,267	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,652	1,652	-1,653	-1	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	28,643	28,643	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	106,517	106,517	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	133,141	33,713	166,854	-30	166,824	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,095,181	6,140,133	24,235,314	-2,598,408	21,636,906	30.00
31.00	03100	INTENSIVE CARE UNIT	2,766,508	985,240	3,751,748	-316,903	3,434,845	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,291,285	785,949	3,077,234	-256,677	2,820,557	34.00
41.00	04100	SUBPROVIDER - IRF	2,021,842	2,465,231	4,487,073	-1,373,882	3,113,191	41.00
43.00	04300	NURSERY	820,992	185,053	1,006,045	441,052	1,447,097	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,319,148	18,702,244	24,021,392	-13,098,023	10,923,369	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,005,704	1,005,704	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,332,558	2,127,278	4,459,836	-1,382,921	3,076,915	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	223,051	335,781	558,832	-99,713	459,119	55.00
56.00	05600	RADIOISOTOPE	1,022,039	2,827,258	3,849,297	-2,389,789	1,459,508	56.00
57.00	05700	CT SCAN	484,707	355,951	840,658	-105,723	734,935	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	251,027	508,753	759,780	-229,650	530,130	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,281,107	5,630,660	6,911,767	-5,246,720	1,665,047	59.00
60.00	06000	LABORATORY	0	7,427,851	7,427,851	-154,527	7,273,324	60.00
64.00	06400	INTRAVENOUS THERAPY	328,726	104,166	432,892	-12,712	420,180	64.00
65.00	06500	RESPIRATORY THERAPY	1,363,587	790,834	2,154,421	-339,477	1,814,944	65.00
66.00	06600	PHYSICAL THERAPY	78,537	5,254,840	5,333,377	1,134,374	6,467,751	66.00
69.00	06900	ELECTROCARDIOLOGY	612,442	332,823	945,265	-160,650	784,615	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	131,588	53,828	185,416	-15,727	169,689	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,818,261	13,818,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,209,199	9,209,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,273,739	8,273,739	73.00
74.00	07400	RENAL DIALYSIS	366,502	292,266	658,768	-84,187	574,581	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	58,259	12,926	71,185	-346	70,839	76.10
76.97	07697	CARDIAC REHABILITATION	256,976	58,544	315,520	-4,775	310,745	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,782,129	2,390,889	6,173,018	-421,995	5,751,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		3,397,508	3,397,508	-3,397,508	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	55,476,373	126,024,157	181,500,530	169,232	181,669,762	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	558,961	1,624,201	2,183,162	-169,232	2,013,930	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	56,035,334	127,648,358	183,683,692	0	183,683,692	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A

Date/Time Prepared:
11/28/2018 4:11 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	-787,636	3,143,364	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	918,760	9,206,170	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	219,778	218,913	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,862,387	55,533,628	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-41,427	7,148,062	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	554,554	8.00
9.00	00900	HOUSEKEEPING	0	2,298,261	9.00
10.00	01000	DIETARY	0	1,718,037	10.00
11.00	01100	CAFETERIA	-732,284	856,334	11.00
13.00	01300	NURSING ADMINISTRATION	-1,985	2,599,609	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	890,257	621,217	14.00
15.00	01500	PHARMACY	-2,672	2,548,595	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,574,991	1,574,990	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	28,643	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-1,119	105,398	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	166,824	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-277,314	21,359,592	30.00
31.00	03100	INTENSIVE CARE UNIT	272,818	3,707,663	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	2,820,557	34.00
41.00	04100	SUBPROVIDER - IRF	-46,044	3,067,147	41.00
43.00	04300	NURSERY	-35,424	1,411,673	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,288,941	9,634,428	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-77,518	928,186	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,665	3,073,250	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	-2,238	456,881	55.00
56.00	05600	RADIOISOTOPE	0	1,459,508	56.00
57.00	05700	CT SCAN	0	734,935	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	530,130	58.00
59.00	05900	CARDIAC CATHETERIZATION	-759	1,664,288	59.00
60.00	06000	LABORATORY	-122,676	7,150,648	60.00
64.00	06400	INTRAVENOUS THERAPY	0	420,180	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,814,944	65.00
66.00	06600	PHYSICAL THERAPY	-246,445	6,221,306	66.00
69.00	06900	ELECTROCARDIOLOGY	-2,288	782,327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	169,689	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,818,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,209,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,273,739	73.00
74.00	07400	RENAL DIALYSIS	-1,119	573,462	74.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	70,839	76.10
76.97	07697	CARDIAC REHABILITATION	-21,140	289,605	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-922,214	4,828,809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,124,083	192,793,845	118.00
NONREIMBURSABLE COST CENTERS					
192.01	19201	OTHER NRCC	0	2,013,930	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	11,124,083	194,807,775	200.00

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet A-6
Date/Time Prepared:
11/28/2018 4:11 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS CAFETERIA COSTS					
1.00	CAFETERIA	11.00	602,928	1,001,623		1.00
	0		602,928	1,001,623		
	B - SHARED RADIOLOGY					
1.00	RADIOLOGY - THERAPEUTIC	55.00	31,219	8,026		1.00
2.00	RADIOISOTOPE	56.00	143,047	67,579		2.00
3.00	CT SCAN	57.00	67,841	8,508		3.00
4.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	35,134	12,161		4.00
	0		277,241	96,274		
	C - RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,084,054		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,313,454		2.00
	0		0	3,397,508		
	D - RECLASS MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	13,818,261		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,209,199		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
	0		0	23,027,460		
	E - RECLASS DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,777,198		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,946,413		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/28/2018 4:11 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36.00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38.00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
42.00		0.00	0	0		42.00
43.00		0.00	0	0		43.00
44.00		0.00	0	0		44.00
45.00		0.00	0	0		45.00
46.00		0.00	0	0		46.00
47.00		0.00	0	0		47.00
48.00		0.00	0	0		48.00
49.00		0.00	0	0		49.00
50.00		0.00	0	0		50.00
51.00		0.00	0	0		51.00
52.00		0.00	0	0		52.00
53.00		0.00	0	0		53.00
54.00		0.00	0	0		54.00
55.00		0.00	0	0		55.00
56.00		0.00	0	0		56.00
57.00		0.00	0	0		57.00
58.00		0.00	0	0		58.00
59.00		0.00	0	0		59.00
60.00		0.00	0	0		60.00
61.00		0.00	0	0		61.00
62.00		0.00	0	0		62.00
63.00		0.00	0	0		63.00
64.00		0.00	0	0		64.00
65.00		0.00	0	0		65.00
	0		0	8,723,611		
	H - RECLASS RESIDENT COSTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	28,643	0		1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	100,517		2.00
3.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	6,000		3.00
	0		28,643	106,517		
	I - LDR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	828,855	284,489		1.00
2.00	NURSERY	43.00	393,151	134,942		2.00
	0		1,222,006	419,431		
	J - PHARMACY RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,547,997		1.00
	TOTALS		0	8,547,997		
	K - REHAB CARE RECLASSIFICATION					
1.00	PHYSICAL THERAPY	66.00	0	1,282,865		1.00
	TOTALS		0	1,282,865		
	L - OTHER RECLASSIFICATIONS					
1.00	ADULTS & PEDIATRICS	30.00	0	1,850		1.00
2.00	EMERGENCY	91.00	0	76,884		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	82,500		3.00

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/28/2018 4:11 am

Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00	ADULTS & PEDIATRICS	30.00	0	36,500		4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	34,639	866,507		5.00
	TOTALS		34,639	1,064,241		
500.00	Grand Total: Increases		2,165,457	47,667,527		500.00

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/28/2018 4:11 am

	Decreases					11/28/2018 4:11 am	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	602,928	1,001,623	0	1.00	
	0		602,928	1,001,623			
	B - SHARED RADIOLOFY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	31,219	8,026	0	1.00	
2.00	RADIOLOGY-DIAGNOSTIC	54.00	143,047	67,579	0	2.00	
3.00	RADIOLOGY-DIAGNOSTIC	54.00	67,841	8,508	0	3.00	
4.00	RADIOLOGY-DIAGNOSTIC	54.00	35,134	12,161	0	4.00	
	0		277,241	96,274			
	C - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,084,054	11	1.00	
2.00	INTEREST EXPENSE	113.00	0	2,313,454	11	2.00	
	0		0	3,397,508			
	D - RECLASS MEDICAL SUPPLIES						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	274,168	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	859,284	0	2.00	
3.00	INTENSIVE CARE UNIT	31.00	0	274,989	0	3.00	
4.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	243,337	0	4.00	
5.00	SUBPROVIDER - IRF	41.00	0	83,443	0	5.00	
6.00	NURSERY	43.00	0	61,632	0	6.00	
7.00	OPERATING ROOM	50.00	0	6,392,769	0	7.00	
8.00	DELIVERY ROOM & LABOR ROOM	52.00	0	66,335	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	112,177	0	9.00	
10.00	RADIOLOGY - THERAPEUTIC	55.00	0	6,954	0	10.00	
11.00	RADIOISOTOPE	56.00	0	2,245,229	0	11.00	
12.00	CT SCAN	57.00	0	11,366	0	12.00	
13.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	6,986	0	13.00	
14.00	CARDIAC CATHETERIZATION	59.00	0	2,269,026	0	14.00	
15.00	LABORATORY	60.00	0	22,945	0	15.00	
16.00	INTRAVENOUS THERAPY	64.00	0	10,832	0	16.00	
17.00	RESPIRATORY THERAPY	65.00	0	303,872	0	17.00	
18.00	PHYSICAL THERAPY	66.00	0	126,264	0	18.00	
19.00	ELECTROCARDIOLOGY	69.00	0	15,864	0	19.00	
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,756	0	20.00	
21.00	RENAL DIALYSIS	74.00	0	74,696	0	21.00	
22.00	CARDIAC REHABILITATION	76.97	0	2,174	0	22.00	
23.00	EMERGENCY	91.00	0	343,163	0	23.00	
24.00	ADULTS & PEDIATRICS	30.00	0	3,960	0	24.00	
25.00	INTENSIVE CARE UNIT	31.00	0	7,745	0	25.00	
26.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	3,046	0	26.00	
28.00	NURSERY	43.00	0	2,661	0	28.00	
29.00	OPERATING ROOM	50.00	0	6,163,964	0	29.00	
30.00	DELIVERY ROOM & LABOR ROOM	52.00	0	3,117	0	30.00	
31.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,610	0	31.00	
32.00	RADIOISOTOPE	56.00	0	297,825	0	32.00	
33.00	CT SCAN	57.00	0	3,856	0	33.00	
34.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	1,246	0	34.00	
35.00	CARDIAC CATHETERIZATION	59.00	0	2,706,177	0	35.00	
36.00	LABORATORY	60.00	0	51	0	36.00	
37.00	INTRAVENOUS THERAPY	64.00	0	1,422	0	37.00	
38.00	RESPIRATORY THERAPY	65.00	0	622	0	38.00	
39.00	PHYSICAL THERAPY	66.00	0	322	0	39.00	
40.00	RENAL DIALYSIS	74.00	0	178	0	40.00	
41.00	EMERGENCY	91.00	0	10,307	0	41.00	
42.00	DRUGS CHARGED TO PATIENTS	73.00	0	90	0	42.00	
	0		0	23,027,460			
	E - RECLASS DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	570	9	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,318,370	9	2.00	
3.00	OPERATION OF PLANT	7.00	0	892,487	9	3.00	
4.00	DIETARY	10.00	0	6,055	9	4.00	
5.00	NURSING ADMINISTRATION	13.00	0	89	9	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	26	9	6.00	
7.00	PHARMACY	15.00	0	1,291	9	7.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	111	9	8.00	
9.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	30	9	9.00	
10.00	ADULTS & PEDIATRICS	30.00	0	24,861	9	10.00	
11.00	INTENSIVE CARE UNIT	31.00	0	5,954	9	11.00	
12.00	SUBPROVIDER - IRF	41.00	0	3,188	9	12.00	
13.00	NURSERY	43.00	0	5,324	9	13.00	
14.00	OPERATING ROOM	50.00	0	100,896	9	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	175,426	9	15.00	

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/28/2018 4:11 am

		Decreases					11/28/2018 4:11 am	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
16.00	RADIOLOGY - THERAPEUTIC	55.00	0	800	9		16.00	
17.00	RADIOISOTOPE	56.00	0	49	9		17.00	
18.00	CT SCAN	57.00	0	54	9		18.00	
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	503	9		19.00	
20.00	CARDIAC CATHETERIZATION	59.00	0	22,721	9		20.00	
21.00	LABORATORY	60.00	0	4,346	9		21.00	
22.00	INTRAVENOUS THERAPY	64.00	0	43	9		22.00	
23.00	RESPIRATORY THERAPY	65.00	0	152	9		23.00	
24.00	PHYSICAL THERAPY	66.00	0	4,526	9		24.00	
25.00	ELECTROCARDIOLOGY	69.00	0	18	9		25.00	
26.00	OUTPATIENT PSYCH	76.10	0	271	9		26.00	
27.00	EMERGENCY	91.00	0	40,622	9		27.00	
28.00	OTHER NRCC	192.01	0	152,557	9		28.00	
29.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	295	9		29.00	
30.00	ADMINISTRATIVE & GENERAL	5.00	0	2,968,599	9		30.00	
31.00	OPERATION OF PLANT	7.00	0	188,683	9		31.00	
32.00	LAUNDRY & LINEN SERVICE	8.00	0	95	9		32.00	
33.00	HOUSEKEEPING	9.00	0	33,879	9		33.00	
34.00	DIETARY	10.00	0	6,126	9		34.00	
35.00	NURSING ADMINISTRATION	13.00	0	152,521	9		35.00	
36.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,429	9		36.00	
37.00	PHARMACY	15.00	0	3,775	9		37.00	
38.00	MEDICAL RECORDS & LIBRARY	16.00	0	1,542	9		38.00	
39.00	ADULTS & PEDIATRICS	30.00	0	68,866	9		39.00	
40.00	INTENSIVE CARE UNIT	31.00	0	28,215	9		40.00	
41.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	10,294	9		41.00	
42.00	SUBPROVIDER - IRF	41.00	0	4,386	9		42.00	
43.00	NURSERY	43.00	0	17,424	9		43.00	
44.00	OPERATING ROOM	50.00	0	440,394	9		44.00	
45.00	RADIOLOGY-DIAGNOSTIC	54.00	0	719,193	9		45.00	
46.00	RADIOLOGY - THERAPEUTIC	55.00	0	131,204	9		46.00	
47.00	RADIOISOTOPE	56.00	0	57,312	9		47.00	
48.00	CT SCAN	57.00	0	166,796	9		48.00	
49.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	268,210	9		49.00	
50.00	CARDIAC CATHETERIZATION	59.00	0	248,796	9		50.00	
51.00	LABORATORY	60.00	0	127,185	9		51.00	
52.00	INTRAVENOUS THERAPY	64.00	0	415	9		52.00	
53.00	RESPIRATORY THERAPY	65.00	0	34,831	9		53.00	
54.00	PHYSICAL THERAPY	66.00	0	17,379	9		54.00	
55.00	ELECTROCARDIOLOGY	69.00	0	144,768	9		55.00	
56.00	ELECTROENCEPHALOGRAPHY	70.00	0	4,971	9		56.00	
57.00	RENAL DIALYSIS	74.00	0	9,313	9		57.00	
58.00	OUTPATIENT PSYCH	76.10	0	75	9		58.00	
59.00	CARDIAC REHABILITATION	76.97	0	2,601	9		59.00	
60.00	EMERGENCY	91.00	0	27,903	9		60.00	
61.00	OTHER NRCC	192.01	0	16,675	9		61.00	
62.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11,160	9		62.00	
63.00	DELIVERY ROOM & LABOR ROOM	52.00	0	27,028	9		63.00	
64.00	CAFETERIA	11.00	0	4,698	9		64.00	
65.00	CAFETERIA	11.00	0	11,235	9		65.00	
			0	8,723,611				
H - RECLASS RESIDENT COSTS								
1.00	ADMINISTRATIVE & GENERAL	5.00	28,643	0	0		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	100,517	0		2.00	
3.00	ADMINISTRATIVE & GENERAL	5.00	0	6,000	0		3.00	
			28,643	106,517				
I - LDR RECLASS								
1.00	ADULTS & PEDIATRICS	30.00	828,855	284,489	0		1.00	
2.00	ADULTS & PEDIATRICS	30.00	393,151	134,942	0		2.00	
			1,222,006	419,431				
J - PHARMACY RECLASS								
1.00	PHARMACY	15.00	0	8,547,997	0		1.00	
	TOTALS		0	8,547,997				
K - REHAB CARE RECLASSIFICATION								
1.00	SUBPROVIDER - IRF	41.00	0	1,282,865	0		1.00	
	TOTALS		0	1,282,865				
L - OTHER RECLASSIFICATIONS								
1.00	ADULTS & PEDIATRICS	30.00	1,850	0	0		1.00	
2.00	EMERGENCY	91.00	76,884	0	0		2.00	
3.00	INTENSIVE CARE UNIT	31.00	82,500	0	0		3.00	
4.00	ADULTS & PEDIATRICS	30.00	36,500	0	0		4.00	
5.00	ADMINISTRATIVE & GENERAL	5.00	34,639	866,507	0		5.00	

RECLASSIFICATIONS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/28/2018 4:11 am

	Decreases				wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	TOTALS		232,373	866,507		
500.00	Grand Total: Decreases		2,363,191	47,469,793		

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet A-7
Part I
Date/Time Prepared:
11/28/2018 4:11 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,848,395	6,101,605	0	6,101,605	0	1.00	
2.00	Land Improvements	2,864,683	24,279	0	24,279	1,700,366	2.00	
3.00	Buildings and Fixtures	342,634,922	5,824,580	0	5,824,580	256,203,121	3.00	
4.00	Building Improvements	4,379,435	6,288,630	0	6,288,630	6,965,924	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	132,888,210	6,669,595	0	6,669,595	115,268,016	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	484,615,645	24,908,689	0	24,908,689	380,137,427	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	484,615,645	24,908,689	0	24,908,689	380,137,427	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	7,950,000	0				1.00	
2.00	Land Improvements	1,188,596	0				2.00	
3.00	Buildings and Fixtures	92,256,381	0				3.00	
4.00	Building Improvements	3,702,141	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	24,289,789	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	129,386,907	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	129,386,907	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet A-7
Part II
Date/Time Prepared:
11/28/2018 4:11 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	9,213	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)	9,213	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	9,213				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	9,213				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet A-7
Part III
Date/Time Prepared:
11/28/2018 4:11 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	33,292,081	0	33,292,081	0.687294	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,147,303	0	15,147,303	0.312706	0	2.00
3.00	Total (sum of lines 1-2)	48,439,384	0	48,439,384	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	60,535	60,535	669,764	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	27,543	27,543	7,238,495	0	2.00
3.00	Total (sum of lines 1-2)	0	88,078	88,078	7,908,259	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	2,413,065	0	0	60,535	3,143,364	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,940,132	0	0	27,543	9,206,170	2.00
3.00	Total (sum of lines 1-2)	4,353,197	0	0	88,078	12,349,534	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-8

Date/Time Prepared:
11/28/2018 4:11 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		B	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-174,934	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-373,322	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-41,427	OPERATION OF PLANT	7.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,537,159			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	14,941,151			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-732,284	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		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	936,123	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	1,274,911	CAP REL COSTS-MVBLE EQUIP	2.00	9	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	MISC INCOME	B	774	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-8

Date/Time Prepared:
11/28/2018 4:11 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	4.00	5.00	
34.00	MISC INCOME	B	-60,813	ADMINISTRATIVE & GENERAL	5.00	0	34.00
35.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	35.00
36.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.00
37.00	MISC INCOME	B	-156	NURSING ADMINISTRATION	13.00	0	37.00
38.00	MISC INCOME	B	-2,672	PHARMACY	15.00	0	38.00
39.00	UNCLAIMED PROPERTY EXEMPTIONS	B	-23,150	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	MISC INCOME	B	-14,820	ADULTS & PEDIATRICS	30.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	MISC INCOME	B	-75	RADIOLOGY-DIAGNOSTIC	54.00	0	42.00
42.01	MISC INCOME	B	-2,818	DELIVERY ROOM & LABOR ROOM	52.00	0	42.01
43.00	MISC INCOME	B	-12,896	LABORATORY	60.00	0	43.00
44.00	MISC INCOME	B	-9,853	PHYSICAL THERAPY	66.00	0	44.00
44.01	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.01
44.02	MISC INCOME	B	-21,140	CARDIAC REHABILITATION	76.97	0	44.02
44.03	INTERCOMPANY RENTAL INCOME	B	-371,320	ADMINISTRATIVE & GENERAL	5.00	0	44.03
45.00	RENTAL INCOME	B	-80,824	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	RENTAL INCOME	B	-1,719	RADIOLOGY-DIAGNOSTIC	54.00	0	45.01
45.02	OTHER REVENUE ALLOWANCES	B	-888	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	MARKETING AND ADVERTISING	A	-380	NURSING ADMINISTRATION	13.00	0	45.03
46.00	MARKETING AND ADVERTISING	A	-964	PHYSICAL THERAPY	66.00	0	46.00
46.01	MARKETING AND ADVERTISING	A	100	OPERATING ROOM	50.00	0	46.01
46.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.02
46.03	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	46.03
47.01	CONTRIBUTIONS CHARITABLE	A	-244,377	ADMINISTRATIVE & GENERAL	5.00	0	47.01
48.00	PATIENT TRANSPORTATION	A	-235,628	PHYSICAL THERAPY	66.00	0	48.00
48.01	INCOME AND REAL ESTATE TAX	A	-32,439	ADMINISTRATIVE & GENERAL	5.00	0	48.01
48.02	CBISA CONTRIBUTION	A	-43,750	ADMINISTRATIVE & GENERAL	5.00	0	48.02
48.03	INVESTMENT INCOME MEDICAL STAFF	A	-9,168	ADMINISTRATIVE & GENERAL	5.00	0	48.03
48.04	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	48.04
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		11,124,083				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: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-8-1

Date/Time Prepared:
11/28/2018 4:11 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DEPRECIATION	-3,197,696	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	219,004	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATION	27,386,996	23,238,338	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	IT	4,549,422	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	PATIENT ACCOUNTS	3,055,596	0	3.02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	RENT EXPENSE	144,926	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,574,991	0	3.04
3.05	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	890,257	0	3.05
3.06	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION	17,171	0	3.06
3.07	31.00	INTENSIVE CARE UNIT	ICU	430,318	0	3.07
3.08	5.00	ADMINISTRATIVE & GENERAL	ADMITTING	1,691,800	0	3.08
3.09	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST CRC B&F (LOSS ON DE	2,051,172	0	3.09
3.10	1.00	CAP REL COSTS-BLDG & FIXT	INT INCOME OFFSET B & F	-547,227	0	3.10
3.11	0.00			0	0	3.11
4.00	60.00	LABORATORY	PURCHASE FEE	6,366,040	6,453,281	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			44,632,770	29,691,619	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	
	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	PRESENCE HEALTH	100.00		0.00	6.00
7.00	C	APHL LABS	66.67		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-8-1

Date/Time Prepared:
11/28/2018 4:11 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	-3,197,696	9		1.00
2.00	219,004	0		2.00
3.00	4,148,658	0		3.00
3.01	4,549,422	0		3.01
3.02	3,055,596	0		3.02
3.03	144,926	9		3.03
3.04	1,574,991	0		3.04
3.05	890,257	0		3.05
3.06	17,171	9		3.06
3.07	430,318	0		3.07
3.08	1,691,800	0		3.08
3.09	2,051,172	11		3.09
3.10	-547,227	11		3.10
3.11	0	0		3.11
4.00	-87,241	0		4.00
5.00	14,941,151			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet A-8-2

Date/Time Prepared:

11/28/2018 4:11 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	879,662	658,206	221,456	211,500	1,606	1.00
2.00	13.00	NURSING ADMINISTRATION	6,330	330	6,000	211,500	48	2.00
3.00	55.00	RADIOLOGY - THERAPEUTIC	12,000	0	12,000	211,500	96	3.00
4.00	30.00	ADULTS & PEDIATRICS	268,290	261,140	7,150	211,500	57	4.00
5.00	31.00	INTENSIVE CARE UNIT	157,500	157,500	0	211,500	0	5.00
6.00	41.00	SUBPROVIDER - IRF	46,044	46,044	0	211,500	0	6.00
7.00	50.00	OPERATING ROOM	1,292,595	1,286,595	6,000	246,400	30	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	12,852	0	12,852	271,900	84	8.00
9.00	60.00	LABORATORY	37,556	19,556	18,000	260,300	120	9.00
10.00	65.00	RESPIRATORY THERAPY	15,163	0	15,163	211,500	153	10.00
11.00	69.00	ELECTROCARDIOLOGY	12,050	0	12,050	211,500	96	11.00
12.00	91.00	EMERGENCY	925,468	921,530	3,938	211,500	32	12.00
13.00	74.00	RENAL DIALYSIS	6,000	0	6,000	211,500	48	13.00
14.00	52.00	DELIVERY ROOM & LABOR ROOM	74,700	74,700	0	237,100	0	14.00
15.00	59.00	CARDIAC CATHETERIZATION	14,500	0	14,500	246,400	116	15.00
16.00	15.00	PHARMACY	0	0	0	211,500	0	16.00
17.00	43.00	NURSERY	35,424	35,424	0	169,700	0	17.00
18.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	6,000	0	6,000	211,500	48	18.00
19.00	64.00	INTRAVENOUS THERAPY	100	0	100	211,500	1	19.00
200.00			3,802,234	3,461,025	341,209		2,535	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	163,302	8,165	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	4,881	244	0	0	0	2.00
3.00	55.00	RADIOLOGY - THERAPEUTIC	9,762	488	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	5,796	290	0	0	0	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	3,554	178	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	10,981	549	0	0	0	8.00
9.00	60.00	LABORATORY	15,017	751	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	15,558	778	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	9,762	488	0	0	0	11.00
12.00	91.00	EMERGENCY	3,254	163	0	0	0	12.00
13.00	74.00	RENAL DIALYSIS	4,881	244	0	0	0	13.00
14.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	14.00
15.00	59.00	CARDIAC CATHETERIZATION	13,741	687	0	0	0	15.00
16.00	15.00	PHARMACY	0	0	0	0	0	16.00
17.00	43.00	NURSERY	0	0	0	0	0	17.00
18.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	4,881	244	0	0	0	18.00
19.00	64.00	INTRAVENOUS THERAPY	102	5	0	0	0	19.00
200.00			265,472	13,274	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	163,302	58,154	716,360		1.00
2.00	13.00	NURSING ADMINISTRATION	0	4,881	1,119	1,449		2.00
3.00	55.00	RADIOLOGY - THERAPEUTIC	0	9,762	2,238	2,238		3.00
4.00	30.00	ADULTS & PEDIATRICS	0	5,796	1,354	262,494		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	157,500		5.00
6.00	41.00	SUBPROVIDER - IRF	0	0	0	46,044		6.00
7.00	50.00	OPERATING ROOM	0	3,554	2,446	1,289,041		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	10,981	1,871	1,871		8.00
9.00	60.00	LABORATORY	0	15,017	2,983	22,539		9.00
10.00	65.00	RESPIRATORY THERAPY	0	15,558	0	0		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	9,762	2,288	2,288		11.00
12.00	91.00	EMERGENCY	0	3,254	684	922,214		12.00
13.00	74.00	RENAL DIALYSIS	0	4,881	1,119	1,119		13.00
14.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	74,700		14.00
15.00	59.00	CARDIAC CATHETERIZATION	0	13,741	759	759		15.00
16.00	15.00	PHARMACY	0	0	0	0		16.00
17.00	43.00	NURSERY	0	0	0	35,424		17.00
18.00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	0	4,881	1,119	1,119		18.00
19.00	64.00	INTRAVENOUS THERAPY	0	102	0	0		19.00
200.00			0	265,472	76,134	3,537,159		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part I
Date/Time Prepared:
11/28/2018 4:11 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	3,143,364	3,143,364				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	9,206,170		9,206,170			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	218,913	14,829	457	234,199		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	55,533,628	170,808	4,595,956	15,566	60,315,958	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,148,062	515,481	292,117	6,127	7,961,787	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	554,554	20,861	147	342	575,904	8.00
9.00	00900	HOUSEKEEPING	2,298,261	39,374	52,451	5,073	2,395,159	9.00
10.00	01000	DIETARY	1,718,037	44,017	9,484	2,592	1,774,130	10.00
11.00	01100	CAFETERIA	856,334	34,154	17,394	2,529	910,411	11.00
13.00	01300	NURSING ADMINISTRATION	2,599,609	20,160	236,131	7,583	2,863,483	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	621,217	28,254	8,405	0	657,876	14.00
15.00	01500	PHARMACY	2,548,595	12,357	5,844	8,109	2,574,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,574,990	34,839	2,387	0	1,612,216	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	28,643	0	0	120	28,763	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	105,398	0	0	0	105,398	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	166,824	786	0	558	168,168	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	21,359,592	791,064	106,618	70,623	22,327,897	30.00
31.00	03100	INTENSIVE CARE UNIT	3,707,663	89,654	43,682	11,257	3,852,256	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,820,557	71,138	15,937	9,610	2,917,242	34.00
41.00	04100	SUBPROVIDER - IRF	3,067,147	56,001	6,790	8,480	3,138,418	41.00
43.00	04300	NURSERY	1,411,673	50,418	26,976	5,092	1,494,159	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,634,428	326,033	681,814	22,309	10,664,584	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	928,186	50,100	41,844	3,476	1,023,606	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,073,250	146,113	1,113,447	8,620	4,341,430	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	456,881	31,443	203,129	1,066	692,519	55.00
56.00	05600	RADIOISOTOPE	1,459,508	14,610	88,730	4,886	1,567,734	56.00
57.00	05700	CT SCAN	734,935	7,095	258,232	2,317	1,002,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	530,130	7,921	415,240	1,200	954,491	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,664,288	29,875	385,183	5,373	2,084,719	59.00
60.00	06000	LABORATORY	7,150,648	42,196	196,907	0	7,389,751	60.00
64.00	06400	INTRAVENOUS THERAPY	420,180	13,559	642	1,379	435,760	64.00
65.00	06500	RESPIRATORY THERAPY	1,814,944	15,383	53,925	5,719	1,889,971	65.00
66.00	06600	PHYSICAL THERAPY	6,221,306	100,164	26,906	329	6,348,705	66.00
69.00	06900	ELECTROCARDIOLOGY	782,327	26,535	224,128	2,569	1,035,559	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	169,689	14,610	7,696	552	192,547	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,818,261	0	0	0	13,818,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,209,199	0	0	0	9,209,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,273,739	0	0	0	8,273,739	73.00
74.00	07400	RENAL DIALYSIS	573,462	4,044	14,418	1,537	593,461	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	70,839	1,035	116	244	72,234	76.10
76.97	07697	CARDIAC REHABILITATION	289,605	17,747	4,027	1,078	312,457	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,828,809	107,921	43,199	15,540	4,995,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	192,793,845	2,950,579	9,180,359	231,855	192,572,905	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	2,013,930	192,785	25,811	2,344	2,234,870	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	194,807,775	3,143,364	9,206,170	234,199	194,807,775	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part I
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	60,315,958					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	3,570,647	0	11,532,434			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	258,277	0	98,505	932,686		8.00
9.00	00900	HOUSEKEEPING	1,074,164	0	185,924	0	3,655,247	9.00
10.00	01000	DIETARY	795,649	0	207,849	0	67,544	10.00
11.00	01100	CAFETERIA	408,295	0	161,279	0	52,411	11.00
13.00	01300	NURSING ADMINISTRATION	1,284,195	0	95,196	0	30,936	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	295,040	0	133,417	0	43,356	14.00
15.00	01500	PHARMACY	1,154,775	0	58,352	0	18,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	723,035	0	164,510	0	53,461	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	12,899	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	47,268	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	75,419	0	3,711	0	1,206	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,013,468	0	3,735,467	664,162	1,213,911	30.00
31.00	03100	INTENSIVE CARE UNIT	1,727,633	0	423,351	62,117	137,576	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,308,304	0	335,916	33,842	109,162	34.00
41.00	04100	SUBPROVIDER - IRF	1,407,496	0	264,438	135,266	85,934	41.00
43.00	04300	NURSERY	670,090	0	238,076	37,299	77,367	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,782,778	0	1,539,547	0	500,304	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	459,060	0	236,576	0	76,880	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,947,014	0	689,954	0	224,213	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	310,576	0	148,477	0	48,250	55.00
56.00	05600	RADIOISOTOPE	703,086	0	68,989	0	22,419	56.00
57.00	05700	CT SCAN	449,630	0	33,505	0	10,888	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	428,063	0	37,401	0	12,154	58.00
59.00	05900	CARDIAC CATHETERIZATION	934,940	0	141,071	0	45,844	59.00
60.00	06000	LABORATORY	3,314,104	0	199,252	0	64,751	60.00
64.00	06400	INTRAVENOUS THERAPY	195,427	0	64,026	0	20,806	64.00
65.00	06500	RESPIRATORY THERAPY	847,601	0	72,638	0	23,605	65.00
66.00	06600	PHYSICAL THERAPY	2,847,223	0	472,983	0	153,704	66.00
69.00	06900	ELECTROCARDIOLOGY	464,420	0	125,300	0	40,719	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	86,352	0	68,989	0	22,419	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,197,117	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,130,077	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,710,549	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	266,151	0	19,095	0	6,205	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	32,395	0	4,886	0	1,588	76.10
76.97	07697	CARDIAC REHABILITATION	140,129	0	83,801	0	27,233	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,240,333	0	509,611	0	165,607	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,313,679	0	10,622,092	932,686	3,359,415	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	1,002,279	0	910,342	0	295,832	192.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	60,315,958	0	11,532,434	932,686	3,655,247	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part I
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,845,172					10.00
11.00	01100	CAFETERIA	0	1,532,396				11.00
13.00	01300	NURSING ADMINISTRATION	0	40,110	4,313,920			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,129,689		14.00
15.00	01500	PHARMACY	0	38,676	112,558	2,691	3,960,919	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	3,228	9,397	10	31	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,097,335	624,833	1,818,425	6,560	73,274	30.00
31.00	03100	INTENSIVE CARE UNIT	195,631	85,765	249,618	668	14,506	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	102,078	74,437	216,650	918	16,403	34.00
41.00	04100	SUBPROVIDER - IRF	426,001	80,250	233,553	753	3,182	41.00
43.00	04300	NURSERY	0	35,358	102,891	253	2,177	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	141,193	410,888	13,153	92,882	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,719	74,831	0	2,243	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,327	169,743	1,386	4,834	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	5,006	14,577	44	3	55.00
56.00	05600	RADIOISOTOPE	0	30,875	89,835	197	14,654	56.00
57.00	05700	CT SCAN	0	16,693	48,597	28	23,504	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	8,354	24,327	52	3,171	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	29,350	85,400	533	31,647	59.00
60.00	06000	LABORATORY	0	0	0	35,815	6	60.00
64.00	06400	INTRAVENOUS THERAPY	0	6,142	17,877	61	5,543	64.00
65.00	06500	RESPIRATORY THERAPY	0	49,630	144,449	629	653	65.00
66.00	06600	PHYSICAL THERAPY	0	1,031	2,984	1,206	318	66.00
69.00	06900	ELECTROCARDIOLOGY	0	17,978	52,308	195	1,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,467	10,107	43	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	637,884	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	425,124	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,573,750	73.00
74.00	07400	RENAL DIALYSIS	0	12,449	36,218	140	19,491	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,300	3,797	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	5,440	15,828	43	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	24,127	126,817	369,062	1,303	77,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,845,172	1,522,428	4,313,920	1,129,689	3,960,919	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	9,968	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,845,172	1,532,396	4,313,920	1,129,689	3,960,919	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part I
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,553,222					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	41,662			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		152,666		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			261,170	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	339,908	0	28,166	103,212	0	30.00
31.00	03100	INTENSIVE CARE UNIT	54,053	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	48,660	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	43,582	0	0	0	0	41.00
43.00	04300	NURSERY	21,298	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	271,772	0	13,496	49,454	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,008	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	137,392	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	3,863	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	66,043	0	0	0	0	56.00
57.00	05700	CT SCAN	164,129	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	51,230	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	109,890	0	0	0	0	59.00
60.00	06000	LABORATORY	277,610	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	8,516	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	61,668	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	125,432	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	80,312	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,348	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	153,724	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	144,659	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,620	0	0	0	261,170	73.00
74.00	07400	RENAL DIALYSIS	9,846	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	1,276	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	4,911	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	223,472	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,553,222	0	41,662	152,666	261,170	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,553,222	0	41,662	152,666	261,170	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part I
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	43,046,618	-131,378	42,915,240	30.00
31.00	03100	INTENSIVE CARE UNIT	6,803,174	0	6,803,174	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,163,612	0	5,163,612	34.00
41.00	04100	SUBPROVIDER - IRF	5,818,873	0	5,818,873	41.00
43.00	04300	NURSERY	2,678,968	0	2,678,968	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	18,480,051	-62,950	18,417,101	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,913,923	0	1,913,923	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,574,293	0	7,574,293	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,223,315	0	1,223,315	55.00
56.00	05600	RADIOISOTOPE	2,563,832	0	2,563,832	56.00
57.00	05700	CT SCAN	1,749,553	0	1,749,553	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,519,243	0	1,519,243	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,463,394	0	3,463,394	59.00
60.00	06000	LABORATORY	11,281,289	0	11,281,289	60.00
64.00	06400	INTRAVENOUS THERAPY	754,158	0	754,158	64.00
65.00	06500	RESPIRATORY THERAPY	3,090,844	0	3,090,844	65.00
66.00	06600	PHYSICAL THERAPY	9,953,586	0	9,953,586	66.00
69.00	06900	ELECTROCARDIOLOGY	1,818,375	0	1,818,375	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391,275	0	391,275	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,806,986	0	20,806,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,909,059	0	13,909,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,946,828	0	15,946,828	73.00
74.00	07400	RENAL DIALYSIS	963,056	0	963,056	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	117,476	0	117,476	76.10
76.97	07697	CARDIAC REHABILITATION	589,842	0	589,842	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	8,732,861	0	8,732,861	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	190,354,484	-194,328	190,160,156	118.00
NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	4,453,291	0	4,453,291	192.01
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	194,807,775	-194,328	194,613,447	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,829	457	15,286	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	170,808	4,595,956	4,766,764	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	515,481	292,117	807,598	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,861	147	21,008	8.00
9.00	00900	HOUSEKEEPING	0	39,374	52,451	91,825	9.00
10.00	01000	DIETARY	0	44,017	9,484	53,501	10.00
11.00	01100	CAFETERIA	0	34,154	17,394	51,548	11.00
13.00	01300	NURSING ADMINISTRATION	0	20,160	236,131	256,291	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	28,254	8,405	36,659	14.00
15.00	01500	PHARMACY	0	12,357	5,844	18,201	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,839	2,387	37,226	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	786	0	786	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	791,064	106,618	897,682	30.00
31.00	03100	INTENSIVE CARE UNIT	0	89,654	43,682	133,336	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	71,138	15,937	87,075	34.00
41.00	04100	SUBPROVIDER - IRF	0	56,001	6,790	62,791	41.00
43.00	04300	NURSERY	0	50,418	26,976	77,394	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	326,033	681,814	1,007,847	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,100	41,844	91,944	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	146,113	1,113,447	1,259,560	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	31,443	203,129	234,572	55.00
56.00	05600	RADIOISOTOPE	0	14,610	88,730	103,340	56.00
57.00	05700	CT SCAN	0	7,095	258,232	265,327	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,921	415,240	423,161	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	29,875	385,183	415,058	59.00
60.00	06000	LABORATORY	0	42,196	196,907	239,103	60.00
64.00	06400	INTRAVENOUS THERAPY	0	13,559	642	14,201	64.00
65.00	06500	RESPIRATORY THERAPY	0	15,383	53,925	69,308	65.00
66.00	06600	PHYSICAL THERAPY	0	100,164	26,906	127,070	66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,535	224,128	250,663	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,610	7,696	22,306	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,044	14,418	18,462	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	1,035	116	1,151	76.10
76.97	07697	CARDIAC REHABILITATION	0	17,747	4,027	21,774	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	107,921	43,199	151,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,950,579	9,180,359	12,130,938	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	192,785	25,811	218,596	192.01
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)	0	3,143,364	9,206,170	12,349,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,767,781					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	282,245	0	1,090,243			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,416	0	9,312	50,758		8.00
9.00	00900	HOUSEKEEPING	84,908	0	17,577	0	194,641	9.00
10.00	01000	DIETARY	62,893	0	19,649	0	3,597	10.00
11.00	01100	CAFETERIA	32,274	0	15,247	0	2,791	11.00
13.00	01300	NURSING ADMINISTRATION	101,510	0	9,000	0	1,647	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,322	0	12,613	0	2,309	14.00
15.00	01500	PHARMACY	91,280	0	5,516	0	1,010	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	57,153	0	15,552	0	2,847	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,020	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,736	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	5,962	0	351	0	64	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	791,570	0	353,143	36,145	64,639	30.00
31.00	03100	INTENSIVE CARE UNIT	136,562	0	40,022	3,380	7,326	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	103,416	0	31,757	1,842	5,813	34.00
41.00	04100	SUBPROVIDER - IRF	111,257	0	24,999	7,361	4,576	41.00
43.00	04300	NURSERY	52,968	0	22,507	2,030	4,120	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	378,060	0	145,544	0	26,641	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,287	0	22,365	0	4,094	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,904	0	65,226	0	11,939	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	24,550	0	14,037	0	2,569	55.00
56.00	05600	RADIOISOTOPE	55,576	0	6,522	0	1,194	56.00
57.00	05700	CT SCAN	35,541	0	3,167	0	580	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	33,837	0	3,536	0	647	58.00
59.00	05900	CARDIAC CATHETERIZATION	73,903	0	13,336	0	2,441	59.00
60.00	06000	LABORATORY	261,967	0	18,837	0	3,448	60.00
64.00	06400	INTRAVENOUS THERAPY	15,448	0	6,053	0	1,108	64.00
65.00	06500	RESPIRATORY THERAPY	66,999	0	6,867	0	1,257	65.00
66.00	06600	PHYSICAL THERAPY	225,062	0	44,714	0	8,185	66.00
69.00	06900	ELECTROCARDIOLOGY	36,711	0	11,845	0	2,168	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,826	0	6,522	0	1,194	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	489,857	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	326,466	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	293,304	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	21,038	0	1,805	0	330	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	2,561	0	462	0	85	76.10
76.97	07697	CARDIAC REHABILITATION	11,077	0	7,922	0	1,450	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	177,089	0	48,177	0	8,819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,688,555	0	1,004,182	50,758	178,888	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	79,226	0	86,061	0	15,753	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,767,781	0	1,090,243	50,758	194,641	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	139,809					10.00
11.00	01100	CAFETERIA	0	102,025				11.00
13.00	01300	NURSING ADMINISTRATION	0	2,670	371,613			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	74,903		14.00
15.00	01500	PHARMACY	0	2,575	9,696	178	128,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	215	810	1	1	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	103,061	41,602	156,643	435	2,386	30.00
31.00	03100	INTENSIVE CARE UNIT	9,613	5,710	21,503	44	472	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,016	4,956	18,663	61	534	34.00
41.00	04100	SUBPROVIDER - IRF	20,933	5,343	20,119	50	104	41.00
43.00	04300	NURSERY	0	2,354	8,863	17	71	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	9,400	35,395	872	3,025	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,712	6,446	0	73	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,883	14,622	92	157	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	333	1,256	3	0	55.00
56.00	05600	RADIOISOTOPE	0	2,056	7,739	13	477	56.00
57.00	05700	CT SCAN	0	1,111	4,186	2	765	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	556	2,096	3	103	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,954	7,357	35	1,031	59.00
60.00	06000	LABORATORY	0	0	0	2,375	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	409	1,540	4	181	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,304	12,443	42	21	65.00
66.00	06600	PHYSICAL THERAPY	0	69	257	80	10	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,197	4,506	13	52	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	231	871	3	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	42,293	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	116,379	73.00
74.00	07400	RENAL DIALYSIS	0	829	3,120	9	635	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	87	327	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	362	1,363	3	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,186	8,443	31,792	86	2,509	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	139,809	101,361	371,613	74,903	128,986	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	664	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	139,809	102,025	371,613	74,903	128,986	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS		
					APPRV	APPRV		
			16.00	17.00	21.00	22.00	23.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112,778					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,028			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		3,736		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0			8,226	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,591	0				30.00
31.00	03100	INTENSIVE CARE UNIT	2,398	0				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	2,159	0				34.00
41.00	04100	SUBPROVIDER - IRF	1,933	0				41.00
43.00	04300	NURSERY	945	0				43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	12,056	0				50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	666	0				52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,095	0				54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	171	0				55.00
56.00	05600	RADIOISOTOPE	2,930	0				56.00
57.00	05700	CT SCAN	7,281	0				57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,273	0				58.00
59.00	05900	CARDIAC CATHETERIZATION	4,875	0				59.00
60.00	06000	LABORATORY	12,315	0				60.00
64.00	06400	INTRAVENOUS THERAPY	378	0				64.00
65.00	06500	RESPIRATORY THERAPY	2,736	0				65.00
66.00	06600	PHYSICAL THERAPY	5,564	0				66.00
69.00	06900	ELECTROCARDIOLOGY	3,563	0				69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	326	0				70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,819	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,417	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,661	0				73.00
74.00	07400	RENAL DIALYSIS	437	0				74.00
76.00	03950	OTHER ANCILLARY	0	0				76.00
76.10	03550	OUTPATIENT PSYCH	57	0				76.10
76.97	07697	CARDIAC REHABILITATION	218	0				76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,914	0				91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,778	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	0				192.01
200.00		Cross Foot Adjustments			1,028	3,736	8,226	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	112,778	0	1,028	3,736	8,226	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,466,500	0	2,466,500	30.00
31.00	03100	INTENSIVE CARE UNIT	361,101	0	361,101	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	261,920	0	261,920	34.00
41.00	04100	SUBPROVIDER - IRF	260,020	0	260,020	41.00
43.00	04300	NURSERY	171,602	0	171,602	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,620,297	0	1,620,297	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,814	0	163,814	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,516,041	0	1,516,041	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	277,561	0	277,561	55.00
56.00	05600	RADIOISOTOPE	180,166	0	180,166	56.00
57.00	05700	CT SCAN	318,111	0	318,111	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	466,290	0	466,290	58.00
59.00	05900	CARDIAC CATHETERIZATION	520,341	0	520,341	59.00
60.00	06000	LABORATORY	538,045	0	538,045	60.00
64.00	06400	INTRAVENOUS THERAPY	39,412	0	39,412	64.00
65.00	06500	RESPIRATORY THERAPY	163,351	0	163,351	65.00
66.00	06600	PHYSICAL THERAPY	411,033	0	411,033	66.00
69.00	06900	ELECTROCARDIOLOGY	310,886	0	310,886	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,315	0	38,315	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	538,969	0	538,969	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	361,072	0	361,072	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,344	0	415,344	73.00
74.00	07400	RENAL DIALYSIS	46,765	0	46,765	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	4,746	0	4,746	76.10
76.97	07697	CARDIAC REHABILITATION	44,239	0	44,239	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	440,150	0	440,150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	11,936,091	0	11,936,091	118.00
NONREIMBURSABLE COST CENTERS						
192.01	19201	OTHER NRCC	400,453	0	400,453	192.01
200.00		Cross Foot Adjustments	12,990	0	12,990	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	12,349,534	0	12,349,534	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	960,008					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,946,410				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,529	295	55,837,600			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,166	2,968,599	3,711,503	-60,315,958	134,491,817	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	157,432	188,683	1,460,976	0	7,961,787	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,371	95	81,605	0	575,904	8.00
9.00	00900	HOUSEKEEPING	12,025	33,879	1,209,691	0	2,395,159	9.00
10.00	01000	DIETARY	13,443	6,126	618,049	0	1,774,130	10.00
11.00	01100	CAFETERIA	10,431	11,235	602,928	0	910,411	11.00
13.00	01300	NURSING ADMINISTRATION	6,157	152,521	1,808,135	0	2,863,483	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,629	5,429	0	0	657,876	14.00
15.00	01500	PHARMACY	3,774	3,775	1,933,511	0	2,574,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,640	1,542	0	0	1,612,216	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	28,643	0	28,763	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	105,398	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	240	0	133,141	0	168,168	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	241,598	68,866	16,834,825	0	22,327,897	30.00
31.00	03100	INTENSIVE CARE UNIT	27,381	28,215	2,684,008	0	3,852,256	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	21,726	10,294	2,291,285	0	2,917,242	34.00
41.00	04100	SUBPROVIDER - IRF	17,103	4,386	2,021,842	0	3,138,418	41.00
43.00	04300	NURSERY	15,398	17,424	1,214,143	0	1,494,159	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	99,573	440,394	5,319,148	0	10,664,584	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	15,301	27,028	828,855	0	1,023,606	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,624	719,193	2,055,317	0	4,341,430	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	9,603	131,204	254,270	0	692,519	55.00
56.00	05600	RADIOISOTOPE	4,462	57,312	1,165,086	0	1,567,734	56.00
57.00	05700	CT SCAN	2,167	166,796	552,548	0	1,002,579	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,419	268,210	286,161	0	954,491	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,124	248,796	1,281,107	0	2,084,719	59.00
60.00	06000	LABORATORY	12,887	127,185	0	0	7,389,751	60.00
64.00	06400	INTRAVENOUS THERAPY	4,141	415	328,726	0	435,760	64.00
65.00	06500	RESPIRATORY THERAPY	4,698	34,831	1,363,587	0	1,889,971	65.00
66.00	06600	PHYSICAL THERAPY	30,591	17,379	78,537	0	6,348,705	66.00
69.00	06900	ELECTROCARDIOLOGY	8,104	144,768	612,442	0	1,035,559	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,462	4,971	131,588	0	192,547	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,818,261	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,209,199	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,273,739	73.00
74.00	07400	RENAL DIALYSIS	1,235	9,313	366,502	0	593,461	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	316	75	58,259	0	72,234	76.10
76.97	07697	CARDIAC REHABILITATION	5,420	2,601	256,976	0	312,457	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	32,960	27,903	3,705,245	0	4,995,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	901,130	5,929,738	55,278,639	-60,315,958	132,256,947	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	58,878	16,672	558,961	0	2,234,870	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,143,364	9,206,170	234,199		60,315,958	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.274310	1.548190	0.004194		0.448473	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			15,286		4,767,781	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000274		0.035450	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: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	745,881				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,371	45,060			8.00
9.00	00900	HOUSEKEEPING	0	12,025	0	727,485		9.00
10.00	01000	DIETARY	0	13,443	0	13,443	156,838	10.00
11.00	01100	CAFETERIA	0	10,431	0	10,431	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	6,157	0	6,157	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	8,629	0	8,629	0	14.00
15.00	01500	PHARMACY	0	3,774	0	3,774	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,640	0	10,640	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	240	0	240	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	241,598	32,087	241,598	115,614	30.00
31.00	03100	INTENSIVE CARE UNIT	0	27,381	3,001	27,381	10,784	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	21,726	1,635	21,726	5,627	34.00
41.00	04100	SUBPROVIDER - IRF	0	17,103	6,535	17,103	23,483	41.00
43.00	04300	NURSERY	0	15,398	1,802	15,398	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	99,573	0	99,573	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,301	0	15,301	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,624	0	44,624	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	9,603	0	9,603	0	55.00
56.00	05600	RADIOISOTOPE	0	4,462	0	4,462	0	56.00
57.00	05700	CT SCAN	0	2,167	0	2,167	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,419	0	2,419	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	9,124	0	9,124	0	59.00
60.00	06000	LABORATORY	0	12,887	0	12,887	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	4,141	0	4,141	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,698	0	4,698	0	65.00
66.00	06600	PHYSICAL THERAPY	0	30,591	0	30,591	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,104	0	8,104	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,462	0	4,462	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,235	0	1,235	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	316	0	316	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	5,420	0	5,420	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	32,960	0	32,960	1,330	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	687,003	45,060	668,607	156,838	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	0	58,878	0	58,878	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	11,532,434	932,686	3,655,247	2,845,172	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	15.461493	20.698757	5.024498	18.140833	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,090,243	50,758	194,641	139,809	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	1.461685	1.126454	0.267553	0.891423	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: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description			CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	102,541					11.00
13.00	01300	NURSING ADMINISTRATION	2,684	2,223,690				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	24,471,989			14.00
15.00	01500	PHARMACY	2,588	58,020	58,304	8,834,192		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,058,383,634	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	216	4,844	212	70	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,811	937,342	142,107	163,426	140,758,104	30.00
31.00	03100	INTENSIVE CARE UNIT	5,739	128,670	14,464	32,353	22,410,183	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	4,981	111,676	19,877	36,584	20,174,045	34.00
41.00	04100	SUBPROVIDER - IRF	5,370	120,389	16,312	7,096	18,068,710	41.00
43.00	04300	NURSERY	2,366	53,037	5,473	4,855	8,830,200	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,448	211,800	284,924	207,158	112,675,050	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,721	38,573	0	5,002	6,222,096	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,903	87,497	30,025	10,782	56,961,816	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	335	7,514	962	6	1,601,554	55.00
56.00	05600	RADIOISOTOPE	2,066	46,307	4,271	32,683	27,380,957	56.00
57.00	05700	CT SCAN	1,117	25,050	609	52,422	68,046,836	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	559	12,540	1,135	7,072	21,239,686	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,964	44,021	11,551	70,584	45,559,866	59.00
60.00	06000	LABORATORY	0	0	775,846	13	115,095,510	60.00
64.00	06400	INTRAVENOUS THERAPY	411	9,215	1,314	12,363	3,530,602	64.00
65.00	06500	RESPIRATORY THERAPY	3,321	74,459	13,634	1,456	25,567,097	65.00
66.00	06600	PHYSICAL THERAPY	69	1,538	26,130	709	52,003,283	66.00
69.00	06900	ELECTROCARDIOLOGY	1,203	26,963	4,225	3,532	33,296,891	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	232	5,210	940	6	3,046,233	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	13,818,261	0	63,732,825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9,209,199	0	59,974,510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,970,677	52,910,382	73.00
74.00	07400	RENAL DIALYSIS	833	18,669	3,043	43,472	4,082,085	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	87	1,957	0	0	529,012	76.10
76.97	07697	CARDIAC REHABILITATION	364	8,159	935	0	2,035,938	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,486	190,240	28,236	171,871	92,650,163	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,874	2,223,690	24,471,989	8,834,192	1,058,383,634	118.00
NONREIMBURSABLE COST CENTERS								
192.01	19201	OTHER NRCC	667	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,532,396	4,313,920	1,129,689	3,960,919	2,553,222	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.944227	1.939983	0.046163	0.448362	0.002412	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,025	371,613	74,903	128,986	112,778	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.994968	0.167115	0.003061	0.014601	0.000107	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: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description		INTERNS & RESIDENTS			PARAMED ED PRGM (ASSIGNED TIME)		
		SOCIAL SERVICE (TIME SPENT)	SERVICES-SALAR	SERVICES-OTHER			
			Y & FRINGES APPRV (ASSIGNED TIME)	PRGM COSTS APPRV (ASSIGNED TIME)			
		17.00	21.00	22.00	23.00		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	0				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	3,087			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0		3,087		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0			100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,087	2,087	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	34.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,000	1,000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	3,087	3,087	100	118.00
NONREIMBURSABLE COST CENTERS							
192.01	19201	OTHER NRCC	0	0	0	0	192.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	41,662	152,666	261,170	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	13.495951	49.454487	2,611.700000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,028	3,736	8,226	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.333009	1.210236	82.260000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/28/2018 4:11 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
			Total Cost (from Wkst. B, Part I, col. 26)				
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,915,240		42,915,240	1,354	42,916,594
31.00	03100	INTENSIVE CARE UNIT	6,803,174		6,803,174	0	6,803,174
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,163,612		5,163,612	0	5,163,612
41.00	04100	SUBPROVIDER - IRF	5,818,873		5,818,873	0	5,818,873
43.00	04300	NURSERY	2,678,968		2,678,968	0	2,678,968
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,417,101		18,417,101	2,446	18,419,547
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,913,923		1,913,923	0	1,913,923
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,574,293		7,574,293	1,871	7,576,164
55.00	05500	RADIOLOGY - THERAPEUTIC	1,223,315		1,223,315	2,238	1,225,553
56.00	05600	RADIOISOTOPE	2,563,832		2,563,832	0	2,563,832
57.00	05700	CT SCAN	1,749,553		1,749,553	0	1,749,553
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,519,243		1,519,243	0	1,519,243
59.00	05900	CARDIAC CATHETERIZATION	3,463,394		3,463,394	759	3,464,153
60.00	06000	LABORATORY	11,281,289		11,281,289	2,983	11,284,272
64.00	06400	INTRAVENOUS THERAPY	754,158		754,158	0	754,158
65.00	06500	RESPIRATORY THERAPY	3,090,844	0	3,090,844	0	3,090,844
66.00	06600	PHYSICAL THERAPY	9,953,586	0	9,953,586	0	9,953,586
69.00	06900	ELECTROCARDIOLOGY	1,818,375		1,818,375	2,288	1,820,663
70.00	07000	ELECTROENCEPHALOGRAPHY	391,275		391,275	0	391,275
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,806,986		20,806,986	0	20,806,986
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,909,059		13,909,059	0	13,909,059
73.00	07300	DRUGS CHARGED TO PATIENTS	15,946,828		15,946,828	0	15,946,828
74.00	07400	RENAL DIALYSIS	963,056		963,056	1,119	964,175
76.00	03950	OTHER ANCILLARY	0		0	0	0
76.10	03550	OUTPATIENT PSYCH	117,476		117,476	0	117,476
76.97	07697	CARDIAC REHABILITATION	589,842		589,842	0	589,842
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	8,732,861		8,732,861	684	8,733,545
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,806,165		7,806,165		7,806,165
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
200.00		Subtotal (see instructions)	197,966,321	0	197,966,321	15,742	197,982,063
201.00		Less Observation Beds	7,806,165		7,806,165		7,806,165
202.00		Total (see instructions)	190,160,156	0	190,160,156	15,742	190,175,898

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/28/2018 4:11 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	98,583,463		98,583,463		30.00
31.00	03100	INTENSIVE CARE UNIT	22,410,183		22,410,183		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	20,174,045		20,174,045		34.00
41.00	04100	SUBPROVIDER - IRF	18,068,710		18,068,710		41.00
43.00	04300	NURSERY	8,830,200		8,830,200		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	46,447,692	66,227,358	112,675,050	0.163453	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,595,489	1,626,607	6,222,096	0.307601	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,457,238	45,504,578	56,961,816	0.132971	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	441,003	1,160,551	1,601,554	0.763830	0.000000
56.00	05600	RADIOISOTOPE	11,850,536	15,530,421	27,380,957	0.093636	0.000000
57.00	05700	CT SCAN	24,748,194	43,298,642	68,046,836	0.025711	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,005,297	13,234,389	21,239,686	0.071529	0.000000
59.00	05900	CARDIAC CATHETERIZATION	17,474,159	28,085,707	45,559,866	0.076019	0.000000
60.00	06000	LABORATORY	58,049,526	57,045,984	115,095,510	0.098017	0.000000
64.00	06400	INTRAVENOUS THERAPY	56,813	3,473,789	3,530,602	0.213606	0.000000
65.00	06500	RESPIRATORY THERAPY	20,078,024	5,489,073	25,567,097	0.120891	0.000000
66.00	06600	PHYSICAL THERAPY	22,511,736	29,491,547	52,003,283	0.191403	0.000000
69.00	06900	ELECTROCARDIOLOGY	16,184,124	17,112,767	33,296,891	0.054611	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	983,228	2,063,005	3,046,233	0.128446	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,915,049	27,817,776	63,732,825	0.326472	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,156,441	21,818,069	59,974,510	0.231916	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	35,886,463	17,023,919	52,910,382	0.301393	0.000000
74.00	07400	RENAL DIALYSIS	3,592,092	489,993	4,082,085	0.235923	0.000000
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000
76.10	03550	OUTPATIENT PSYCH	460,484	68,528	529,012	0.222067	0.000000
76.97	07697	CARDIAC REHABILITATION	2,253	2,033,685	2,035,938	0.289715	0.000000
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	28,180,269	64,469,894	92,650,163	0.094256	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,329,518	35,845,123	42,174,641	0.185091	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	559,472,229	498,911,405	1,058,383,634		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	559,472,229	498,911,405	1,058,383,634		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 4:11 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT			34.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.163475		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307601		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133004		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.765227		55.00
56.00	05600	RADIOISOTOPE	0.093636		56.00
57.00	05700	CT SCAN	0.025711		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071529		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076035		59.00
60.00	06000	LABORATORY	0.098043		60.00
64.00	06400	INTRAVENOUS THERAPY	0.213606		64.00
65.00	06500	RESPIRATORY THERAPY	0.120891		65.00
66.00	06600	PHYSICAL THERAPY	0.191403		66.00
69.00	06900	ELECTROCARDIOLOGY	0.054680		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.128446		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.326472		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231916		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301393		73.00
74.00	07400	RENAL DIALYSIS	0.236197		74.00
76.00	03950	OTHER ANCILLARY	0.000000		76.00
76.10	03550	OUTPATIENT PSYCH	0.222067		76.10
76.97	07697	CARDIAC REHABILITATION	0.289715		76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.094264		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.185091		92.00
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: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/28/2018 4:11 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,915,240		42,915,240	1,354	42,916,594	30.00
31.00	03100	INTENSIVE CARE UNIT	6,803,174		6,803,174	0	6,803,174	31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	5,163,612		5,163,612	0	5,163,612	34.00
41.00	04100	SUBPROVIDER - IRF	5,818,873		5,818,873	0	5,818,873	41.00
43.00	04300	NURSERY	2,678,968		2,678,968	0	2,678,968	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	18,417,101		18,417,101	2,446	18,419,547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,913,923		1,913,923	0	1,913,923	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,574,293		7,574,293	1,871	7,576,164	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	1,223,315		1,223,315	2,238	1,225,553	55.00
56.00	05600	RADIOISOTOPE	2,563,832		2,563,832	0	2,563,832	56.00
57.00	05700	CT SCAN	1,749,553		1,749,553	0	1,749,553	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,519,243		1,519,243	0	1,519,243	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,463,394		3,463,394	759	3,464,153	59.00
60.00	06000	LABORATORY	11,281,289		11,281,289	2,983	11,284,272	60.00
64.00	06400	INTRAVENOUS THERAPY	754,158		754,158	0	754,158	64.00
65.00	06500	RESPIRATORY THERAPY	3,090,844	0	3,090,844	0	3,090,844	65.00
66.00	06600	PHYSICAL THERAPY	9,953,586	0	9,953,586	0	9,953,586	66.00
69.00	06900	ELECTROCARDIOLOGY	1,818,375		1,818,375	2,288	1,820,663	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	391,275		391,275	0	391,275	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,806,986		20,806,986	0	20,806,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,909,059		13,909,059	0	13,909,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,946,828		15,946,828	0	15,946,828	73.00
74.00	07400	RENAL DIALYSIS	963,056		963,056	1,119	964,175	74.00
76.00	03950	OTHER ANCILLARY	0		0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	117,476		117,476	0	117,476	76.10
76.97	07697	CARDIAC REHABILITATION	589,842		589,842	0	589,842	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	8,732,861		8,732,861	684	8,733,545	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,806,165		7,806,165		7,806,165	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	197,966,321	0	197,966,321	15,742	197,982,063	200.00
201.00		Less Observation Beds	7,806,165		7,806,165		7,806,165	201.00
202.00		Total (see instructions)	190,160,156	0	190,160,156	15,742	190,175,898	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/28/2018 4:11 am

			Title XIX		Hospital	Cost	
Cost Center Description			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	98,583,463		98,583,463		30.00
31.00	03100	INTENSIVE CARE UNIT	22,410,183		22,410,183		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	20,174,045		20,174,045		34.00
41.00	04100	SUBPROVIDER - IRF	18,068,710		18,068,710		41.00
43.00	04300	NURSERY	8,830,200		8,830,200		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	46,447,692	66,227,358	112,675,050	0.163453	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,595,489	1,626,607	6,222,096	0.307601	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,457,238	45,504,578	56,961,816	0.132971	0.000000
55.00	05500	RADIOLOGY - THERAPEUTIC	441,003	1,160,551	1,601,554	0.763830	0.000000
56.00	05600	RADIOISOTOPE	11,850,536	15,530,421	27,380,957	0.093636	0.000000
57.00	05700	CT SCAN	24,748,194	43,298,642	68,046,836	0.025711	0.000000
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,005,297	13,234,389	21,239,686	0.071529	0.000000
59.00	05900	CARDIAC CATHETERIZATION	17,474,159	28,085,707	45,559,866	0.076019	0.000000
60.00	06000	LABORATORY	58,049,526	57,045,984	115,095,510	0.098017	0.000000
64.00	06400	INTRAVENOUS THERAPY	56,813	3,473,789	3,530,602	0.213606	0.000000
65.00	06500	RESPIRATORY THERAPY	20,078,024	5,489,073	25,567,097	0.120891	0.000000
66.00	06600	PHYSICAL THERAPY	22,511,736	29,491,547	52,003,283	0.191403	0.000000
69.00	06900	ELECTROCARDIOLOGY	16,184,124	17,112,767	33,296,891	0.054611	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	983,228	2,063,005	3,046,233	0.128446	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,915,049	27,817,776	63,732,825	0.326472	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,156,441	21,818,069	59,974,510	0.231916	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	35,886,463	17,023,919	52,910,382	0.301393	0.000000
74.00	07400	RENAL DIALYSIS	3,592,092	489,993	4,082,085	0.235923	0.000000
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	0.000000
76.10	03550	OUTPATIENT PSYCH	460,484	68,528	529,012	0.222067	0.000000
76.97	07697	CARDIAC REHABILITATION	2,253	2,033,685	2,035,938	0.289715	0.000000
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	28,180,269	64,469,894	92,650,163	0.094256	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,329,518	35,845,123	42,174,641	0.185091	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	559,472,229	498,911,405	1,058,383,634		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	559,472,229	498,911,405	1,058,383,634		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/28/2018 4:11 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
31.00	03100	INTENSIVE CARE UNIT				31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT				34.00
41.00	04100	SUBPROVIDER - IRF				41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03950	OTHER ANCILLARY	0.000000			76.00
76.10	03550	OUTPATIENT PSYCH	0.000000			76.10
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
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: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet D
Part I
Date/Time Prepared:
11/28/2018 4:11 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,466,500	0	2,466,500	39,221	62.89	30.00
31.00	INTENSIVE CARE UNIT	361,101		361,101	3,001	120.33	31.00
34.00	SURGICAL INTENSIVE CARE UNIT	261,920		261,920	1,635	160.20	34.00
41.00	SUBPROVIDER - IRF	260,020	0	260,020	6,535	39.79	41.00
43.00	NURSERY	171,602		171,602	1,802	95.23	43.00
200.00	Total (lines 30 through 199)	3,521,143		3,521,143	52,194		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	14,778	929,388				30.00
31.00	INTENSIVE CARE UNIT	1,149	138,259				31.00
34.00	SURGICAL INTENSIVE CARE UNIT	995	159,399				34.00
41.00	SUBPROVIDER - IRF	5,287	210,370				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	22,209	1,437,416				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet D
Part II
Date/Time Prepared:
11/28/2018 4:11 am

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,620,297	112,675,050	0.014380	19,547,538	281,094	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,814	6,222,096	0.026328	3,815	100	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,516,041	56,961,816	0.026615	5,463,979	145,424	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	277,561	1,601,554	0.173307	173,948	30,146	55.00
56.00	05600	RADIOISOTOPE	180,166	27,380,957	0.006580	4,756,335	31,297	56.00
57.00	05700	CT SCAN	318,111	68,046,836	0.004675	13,563,775	63,411	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	466,290	21,239,686	0.021954	3,912,258	85,890	58.00
59.00	05900	CARDIAC CATHETERIZATION	520,341	45,559,866	0.011421	9,364,156	106,948	59.00
60.00	06000	LABORATORY	538,045	115,095,510	0.004675	28,087,837	131,311	60.00
64.00	06400	INTRAVENOUS THERAPY	39,412	3,530,602	0.011163	46,099	515	64.00
65.00	06500	RESPIRATORY THERAPY	163,351	25,567,097	0.006389	9,802,516	62,628	65.00
66.00	06600	PHYSICAL THERAPY	411,033	52,003,283	0.007904	5,947,199	47,007	66.00
69.00	06900	ELECTROCARDIOLOGY	310,886	33,296,891	0.009337	9,619,644	89,819	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	38,315	3,046,233	0.012578	440,761	5,544	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	538,969	63,732,825	0.008457	16,341,359	138,199	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	361,072	59,974,510	0.006020	17,270,155	103,966	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	415,344	52,910,382	0.007850	16,055,210	126,033	73.00
74.00	07400	RENAL DIALYSIS	46,765	4,082,085	0.011456	1,950,605	22,346	74.00
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	4,746	529,012	0.008971	52,848	474	76.10
76.97	07697	CARDIAC REHABILITATION	44,239	2,035,938	0.021729	790	17	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	440,150	92,650,163	0.004751	14,129,654	67,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	448,636	42,174,641	0.010638	2,927,958	31,148	92.00
200.00		Total (lines 50 through 199)	8,863,584	890,317,033		179,458,439	1,570,447	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0007		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/28/2018 4:11 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	0	34.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00		
43.00	04300	NURSERY	0	0	0	0	0	0	43.00		
200.00	Total (lines 30 through 199)		0	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	39,221	0.00	14,778	30.00			
31.00	03100	INTENSIVE CARE UNIT		0	3,001	0.00	1,149	31.00			
34.00	03400	SURGICAL INTENSIVE CARE UNIT		0	1,635	0.00	995	34.00			
41.00	04100	SUBPROVIDER - IRF	0	0	6,535	0.00	5,287	41.00			
43.00	04300	NURSERY		0	1,802	0.00	0	43.00			
200.00	Total (lines 30 through 199)			0	52,194		22,209	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0								34.00
41.00	04100	SUBPROVIDER - IRF	0								41.00
43.00	04300	NURSERY	0								43.00
200.00	Total (lines 30 through 199)		0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 4:11 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								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	261,170	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	261,170	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 4:11 am

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							
50.00	05000	OPERATING ROOM	0	0	112,675,050	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,222,096	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	56,961,816	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	1,601,554	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	27,380,957	0.000000	56.00
57.00	05700	CT SCAN	0	0	68,046,836	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	21,239,686	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	45,559,866	0.000000	59.00
60.00	06000	LABORATORY	0	0	115,095,510	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,530,602	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	25,567,097	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	52,003,283	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	33,296,891	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,046,233	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	63,732,825	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	59,974,510	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	261,170	261,170	0.004936	73.00
74.00	07400	RENAL DIALYSIS	0	0	4,082,085	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	529,012	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	2,035,938	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	92,650,163	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	42,174,641	0.000000	92.00
200.00		Total (lines 50 through 199)	0	261,170	261,170	890,317,033	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 4:11 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							
50.00	05000	OPERATING ROOM	0.000000	19,547,538	0	16,210,780	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	3,815	0	0	0 52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,463,979	0	7,869,116	0 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	173,948	0	718,462	0 55.00
56.00	05600	RADIOISOTOPE	0.000000	4,756,335	0	4,707,854	0 56.00
57.00	05700	CT SCAN	0.000000	13,563,775	0	9,683,219	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,912,258	0	3,892,981	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	9,364,156	0	12,915,690	0 59.00
60.00	06000	LABORATORY	0.000000	28,087,837	0	9,153,899	0 60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	46,099	0	1,799,324	0 64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	9,802,516	0	938,123	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,947,199	0	1,498,675	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	9,619,644	0	4,352,388	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	440,761	0	450,050	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	16,341,359	0	8,729,557	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	17,270,155	0	8,548,041	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.004936	16,055,210	79,249	6,520,426	32,185 73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,950,605	0	251,991	0 74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0 76.00
76.10	03550	OUTPATIENT PSYCH	0.000000	52,848	0	0	0 76.10
76.97	07697	CARDIAC REHABILITATION	0.000000	790	0	918,048	0 76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	14,129,654	0	10,955,185	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,927,958	0	12,984,992	0 92.00
200.00		Total (lines 50 through 199)		179,458,439	79,249	123,098,801	32,185 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet D
Part V
Date/Time Prepared:
11/28/2018 4:11 am

			Title XVIII		Hospital	PPS		
	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							
50.00	05000	OPERATING ROOM	0.163453	16,210,780	0	1,578	2,649,701	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307601	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.132971	7,869,116	0	0	1,046,364	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.763830	718,462	0	0	548,783	55.00
56.00	05600	RADIOISOTOPE	0.093636	4,707,854	0	0	440,825	56.00
57.00	05700	CT SCAN	0.025711	9,683,219	0	0	248,965	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071529	3,892,981	0	0	278,461	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076019	12,915,690	0	0	981,838	59.00
60.00	06000	LABORATORY	0.098017	9,153,899	0	0	897,238	60.00
64.00	06400	INTRAVENOUS THERAPY	0.213606	1,799,324	0	0	384,346	64.00
65.00	06500	RESPIRATORY THERAPY	0.120891	938,123	0	0	113,411	65.00
66.00	06600	PHYSICAL THERAPY	0.191403	1,498,675	0	42	286,851	66.00
69.00	06900	ELECTROCARDIOLOGY	0.054611	4,352,388	0	0	237,688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.128446	450,050	0	0	57,807	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.326472	8,729,557	0	0	2,849,956	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231916	8,548,041	0	0	1,982,427	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301393	6,520,426	0	20,913	1,965,211	73.00
74.00	07400	RENAL DIALYSIS	0.235923	251,991	0	0	59,450	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.222067	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.289715	918,048	0	0	265,972	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.094256	10,955,185	0	0	1,032,592	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.185091	12,984,992	0	0	2,403,405	92.00
200.00		Subtotal (see instructions)		123,098,801	0	22,533	18,731,291	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		123,098,801	0	22,533	18,731,291	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet D
Part V
Date/Time Prepared:
11/28/2018 4:11 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					
50.00	05000	OPERATING ROOM	0	258		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	8		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,303		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	OTHER ANCILLARY	0	0		76.00
76.10	03550	OUTPATIENT PSYCH	0	0		76.10
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
	OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	6,569		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	6,569		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0007		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part II Date/Time Prepared: 11/28/2018 4:11 am	
				Component CCN: 14-T007					
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,620,297	112,675,050	0.014380	29,545	425	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	163,814	6,222,096	0.026328	0	0	52.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,516,041	56,961,816	0.026615	170,724	4,544	54.00	
55.00	05500	RADIOLOGY - THERAPEUTIC	277,561	1,601,554	0.173307	0	0	55.00	
56.00	05600	RADIOISOTOPE	180,166	27,380,957	0.006580	118,661	781	56.00	
57.00	05700	CT SCAN	318,111	68,046,836	0.004675	300,570	1,405	57.00	
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	466,290	21,239,686	0.021954	64,082	1,407	58.00	
59.00	05900	CARDIAC CATHETERIZATION	520,341	45,559,866	0.011421	18,170	208	59.00	
60.00	06000	LABORATORY	538,045	115,095,510	0.004675	2,047,567	9,572	60.00	
64.00	06400	INTRAVENOUS THERAPY	39,412	3,530,602	0.011163	497	6	64.00	
65.00	06500	RESPIRATORY THERAPY	163,351	25,567,097	0.006389	811,507	5,185	65.00	
66.00	06600	PHYSICAL THERAPY	411,033	52,003,283	0.007904	9,438,431	74,601	66.00	
69.00	06900	ELECTROCARDIOLOGY	310,886	33,296,891	0.009337	191,438	1,787	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	38,315	3,046,233	0.012578	9,204	116	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	538,969	63,732,825	0.008457	320,713	2,712	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	361,072	59,974,510	0.006020	40,091	241	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	415,344	52,910,382	0.007850	1,338,718	10,509	73.00	
74.00	07400	RENAL DIALYSIS	46,765	4,082,085	0.011456	480,789	5,508	74.00	
76.00	03950	OTHER ANCILLARY	0	0	0.000000	0	0	76.00	
76.10	03550	OUTPATIENT PSYCH	4,746	529,012	0.008971	0	0	76.10	
76.97	07697	CARDIAC REHABILITATION	44,239	2,035,938	0.021729	12	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	440,150	92,650,163	0.004751	54,035	257	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	42,174,641	0.000000	47,417	0	92.00	
200.00		Total (lines 50 through 199)	8,414,948	890,317,033		15,482,171	119,264	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0007
Component CCN: 14-T007

Period:
From 01/01/2018
To 06/30/2018

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 4:11 am

			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	261,170	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	261,170	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part IV Date/Time Prepared: 11/28/2018 4:11 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	112,675,050	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,222,096	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	56,961,816	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	1,601,554	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	27,380,957	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	68,046,836	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,239,686	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	45,559,866	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	115,095,510	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,530,602	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	25,567,097	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	52,003,283	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	33,296,891	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,046,233	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	63,732,825	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	59,974,510	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	261,170	261,170	52,910,382	0.004936	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,082,085	0.000000	74.00
76.00	03950	OTHER ANCILLARY	0	0	0	0	0.000000	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	0	529,012	0.000000	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	0	2,035,938	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	92,650,163	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	42,174,641	0.000000	92.00
200.00		Total (lines 50 through 199)	0	261,170	261,170	890,317,033		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part IV Date/Time Prepared: 11/28/2018 4:11 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		29,545	0	13	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		170,724	0	1,075	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000		0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000		118,661	0	163	0	56.00
57.00	05700	CT SCAN	0.000000		300,570	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		64,082	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		18,170	0	15	0	59.00
60.00	06000	LABORATORY	0.000000		2,047,567	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		497	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		811,507	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		9,438,431	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		191,438	0	934	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		9,204	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		320,713	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		40,091	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.004936		1,338,718	6,608	166	1	73.00
74.00	07400	RENAL DIALYSIS	0.000000		480,789	0	0	0	74.00
76.00	03950	OTHER ANCILLARY	0.000000		0	0	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.000000		0	0	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0.000000		12	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000		54,035	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		47,417	0	0	0	92.00
200.00		Total (lines 50 through 199)			15,482,171	6,608	2,366	1	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:

Worksheet D

Component CCN: 14-T007

From 01/01/2018
To 06/30/2018Part V
Date/Time Prepared:
11/28/2018 4:11 am

Title XVIII

Subprovider -
IRF

PPS

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						
50.00	05000 OPERATING ROOM	0.163453	13	0	51	2
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.307601	0	0	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.132971	1,075	0	0	143
55.00	05500 RADIOLOGY - THERAPEUTIC	0.763830	0	0	0	0
56.00	05600 RADIOISOTOPE	0.093636	163	0	0	15
57.00	05700 CT SCAN	0.025711	0	0	0	0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071529	0	0	0	0
59.00	05900 CARDIAC CATHETERIZATION	0.076019	15	0	0	1
60.00	06000 LABORATORY	0.098017	0	0	0	0
64.00	06400 INTRAVENOUS THERAPY	0.213606	0	0	0	0
65.00	06500 RESPIRATORY THERAPY	0.120891	0	0	0	0
66.00	06600 PHYSICAL THERAPY	0.191403	0	0	0	0
69.00	06900 ELECTROCARDIOLOGY	0.054611	934	0	0	51
70.00	07000 ELECTROENCEPHALOGRAPHY	0.128446	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.326472	0	0	0	0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.231916	0	0	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.301393	166	0	743	50
74.00	07400 RENAL DIALYSIS	0.235923	0	0	0	0
76.00	03950 OTHER ANCILLARY	0.000000	0	0	0	0
76.10	03550 OUTPATIENT PSYCH	0.222067	0	0	0	0
76.97	07697 CARDIAC REHABILITATION	0.289715	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0.094256	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.185091	0	0	0	0
200.00	Subtotal (see instructions)		2,366	0	794	262
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00	Net Charges (line 200 - line 201)		2,366	0	794	262

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0007

Period:

Worksheet D

Component CCN: 14-T007

From 01/01/2018
To 06/30/2018Part V
Date/Time Prepared:
11/28/2018 4:11 am

Title XVIII

Subprovider -
IRF

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				
50.00	05000	OPERATING ROOM	0	8	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	224	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	OTHER ANCILLARY	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0	0	76.10
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	232	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	232	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		39,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		39,221	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)		32,087	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		14,778	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)		42,916,594	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)		42,916,594	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)		42,916,594	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,094.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		16,170,383	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)		16,170,383	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet D-1

Date/Time Prepared:

11/28/2018 4:11 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)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	6,803,174	3,001	2,266.97	1,149	2,604,749
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT	5,163,612	1,635	3,158.17	995	3,142,379
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					28,037,819
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					49,955,330
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,227,046
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,649,696
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,876,742
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					47,078,588
	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)					7,134
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,094.22
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,806,165

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet D-1

Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description		Title XVIII		Hospital	PPS	
		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	2,466,500	42,916,594	0.057472	7,806,165	448,636 90.00
91.00	Nursing School cost	0	42,916,594	0.000000	7,806,165	0 91.00
92.00	Allied health cost	0	42,916,594	0.000000	7,806,165	0 92.00
93.00	All other Medical Education	0	42,916,594	0.000000	7,806,165	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,535	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,535	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)		6,535	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,287	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)		5,818,873	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)		5,818,873	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)		5,818,873	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)		890.42	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,707,651	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)		4,707,651	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 4:11 am	
				Title XVIII		Subprovider - IRF	PPS
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,814,412	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,522,063	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)					210,370	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					125,872	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					336,242	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,185,821	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: 14-0007

Period:

Worksheet D-1

Component CCN: 14-T007

From 01/01/2018
To 06/30/2018Date/Time Prepared:
11/28/2018 4:11 am

Title XVIII

Subprovider -
IRF

PPS

Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	260,020	5,818,873	0.044686	0	0	90.00
91.00	Nursing School cost	0	5,818,873	0.000000	0	0	91.00
92.00	Allied health cost	0	5,818,873	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,818,873	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 4:11 am	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		45,418,598		30.00
31.00	03100	INTENSIVE CARE UNIT		10,892,174		31.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		9,005,059		34.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.163475	19,547,538	3,195,534	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.307601	3,815	1,173	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133004	5,463,979	726,731	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.765227	173,948	133,110	55.00
56.00	05600	RADIOISOTOPE	0.093636	4,756,335	445,364	56.00
57.00	05700	CT SCAN	0.025711	13,563,775	348,738	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.071529	3,912,258	279,840	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.076035	9,364,156	712,004	59.00
60.00	06000	LABORATORY	0.098043	28,087,837	2,753,816	60.00
64.00	06400	INTRAVENOUS THERAPY	0.213606	46,099	9,847	64.00
65.00	06500	RESPIRATORY THERAPY	0.120891	9,802,516	1,185,036	65.00
66.00	06600	PHYSICAL THERAPY	0.191403	5,947,199	1,138,312	66.00
69.00	06900	ELECTROCARDIOLOGY	0.054680	9,619,644	526,002	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.128446	440,761	56,614	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.326472	16,341,359	5,334,996	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.231916	17,270,155	4,005,225	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.301393	16,055,210	4,838,928	73.00
74.00	07400	RENAL DIALYSIS	0.236197	1,950,605	460,727	74.00
76.00	03950	OTHER ANCILLARY	0.000000	0	0	76.00
76.10	03550	OUTPATIENT PSYCH	0.222067	52,848	11,736	76.10
76.97	07697	CARDIAC REHABILITATION	0.289715	790	229	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.094264	14,129,654	1,331,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.185091	2,927,958	541,939	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		179,458,439	28,037,819	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		179,458,439		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 4:11 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		31,253		30.00
31.00	03100 INTENSIVE CARE UNIT		776		31.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		416		34.00
41.00	04100 SUBPROVIDER - IRF		14,510,003		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.163475	29,545	4,830	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.307601	0	0	52.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.133004	170,724	22,707	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0.765227	0	0	55.00
56.00	05600 RADIOISOTOPE	0.093636	118,661	11,111	56.00
57.00	05700 CT SCAN	0.025711	300,570	7,728	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.071529	64,082	4,584	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.076035	18,170	1,382	59.00
60.00	06000 LABORATORY	0.098043	2,047,567	200,750	60.00
64.00	06400 INTRAVENOUS THERAPY	0.213606	497	106	64.00
65.00	06500 RESPIRATORY THERAPY	0.120891	811,507	98,104	65.00
66.00	06600 PHYSICAL THERAPY	0.191403	9,438,431	1,806,544	66.00
69.00	06900 ELECTROCARDIOLOGY	0.054680	191,438	10,468	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.128446	9,204	1,182	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.326472	320,713	104,704	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.231916	40,091	9,298	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.301393	1,338,718	403,480	73.00
74.00	07400 RENAL DIALYSIS	0.236197	480,789	113,561	74.00
76.00	03950 OTHER ANCILLARY	0.000000	0	0	76.00
76.10	03550 OUTPATIENT PSYCH	0.222067	0	0	76.10
76.97	07697 CARDIAC REHABILITATION	0.289715	12	3	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.094264	54,035	5,094	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.185091	47,417	8,776	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		15,482,171	2,814,412	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		15,482,171		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E
Part A
Date/Time Prepared:
11/28/2018 4:11 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			35,279,574	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)			495,145	2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
3.00	Managed Care Simulated Payments			8,218,964	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			390.51	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			9.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			5.85	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			5.85	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			9.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			2.83	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.85	11.00
12.00	Current year allowable FTE (see instructions)			3.68	12.00
13.00	Total allowable FTE count for the prior year.			3.92	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			1.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			2.87	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			2.87	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.007349	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.006441	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.006441	21.00
22.00	IME payment adjustment (see instructions)			124,008	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			28,890	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			-6.17	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			124,008	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			28,890	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			2.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)			22.91	31.00
32.00	Sum of lines 30 and 31			25.75	32.00
33.00	Allowable disproportionate share percentage (see instructions)			10.46	33.00
34.00	Disproportionate share adjustment (see instructions)			922,561	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,240,618	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,606,990	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,606,990		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	38,428,278		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions))	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		38,457,168	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		3,068,580	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		25,983	52.00
53.00	Nursing and Allied Health Managed Care payment		138,643	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		79,249	58.00
59.00	Total (sum of amounts on lines 49 through 58)		41,769,623	59.00
60.00	Primary payer payments		14,320	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		41,755,303	61.00
62.00	Deductibles billed to program beneficiaries		3,369,904	62.00
63.00	Coinurance billed to program beneficiaries		85,425	63.00
64.00	Allowable bad debts (see instructions)		457,263	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		297,221	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		337,061	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		38,597,195	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-155,579	70.93
70.94	HRR adjustment amount (see instructions)		-867,878	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E
Part A
Date/Time Prepared:
11/28/2018 4:11 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3		0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		37,573,738		71.00
71.01	Sequestration adjustment (see instructions)		751,475		71.01
71.02	Demonstration payment adjustment amount after sequestration		0		71.02
72.00	Interim payments		36,131,894		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		690,369		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		667,038		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	0	94.00
95.00	Time value of money for operating expenses (see instructions)		0	0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	0	96.00
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 4:11 am

				Title XVIII		Hospital	11/28/2018 4:11 am	PPS
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	35,279,574	0	35,279,574		35,279,574	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	495,145	0	495,145	0	495,145	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,218,964	0	8,218,964	0	8,218,964	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.006441	0.006441	0.006441	0.006441		5.00
6.00	IME payment adjustment (see instructions)	22.00	124,008	0	124,008	0	124,008	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	28,890	0	28,890	0	28,890	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	124,008	0	124,008	0	124,008	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	28,890	0	28,890	0	28,890	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1046	0.1046	0.1046	0.1046		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	922,561	0	922,561	0	922,561	11.00
11.01	Uncompensated care payments	36.00	1,606,990	0	2,857,138	806,418	3,663,556	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	38,428,278	0	37,621,860	806,418	38,428,278	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	38,457,168	0	37,650,750	806,418	38,457,168	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,068,580	0	3,068,580	0	3,068,580	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 4:11 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	40,719,330	806,418	41,525,748	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	2,873,438	0	2,873,438	0	2,873,438	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	29,919	0	29,919	0	29,919	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0040	0.0040	0.0040	0.0040		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	11,494	0	11,494	0	11,494	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0535	0.0535	0.0535	0.0535		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	153,729	0	153,729	0	153,729	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,068,580	0	3,068,580	0	3,068,580	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2018 4:11 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	35,279,574	35,279,574		35,279,574	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	495,145	495,145	0	495,145	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	8,218,964	8,218,964	0	8,218,964	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.006441	0.006441	0.006441		5.00
6.00	IME payment adjustment (see instructions)	22.00	124,008	124,008	0	124,008	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	28,890	28,890	0	28,890	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	124,008	124,008	0	124,008	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	28,890	28,890	0	28,890	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1046	0.1046	0.1046		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	922,561	922,561	0	922,561	11.00
11.01	Uncompensated care payments	36.00	1,606,990	1,606,990	0	1,606,990	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	38,428,278	38,428,278	0	38,428,278	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	38,457,168	38,457,168	0	38,457,168	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3,068,580	3,068,580	0	3,068,580	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			41,525,748	0	41,525,748	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2018 4:11 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,873,438	2,873,438	0	2,873,438	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	29,919	29,919	0	29,919	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0040	0.0040	0.0040		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	11,494	11,494	0	11,494	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0535	0.0535	0.0535		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	153,729	153,729	0	153,729	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3,068,580	3,068,580	0	3,068,580	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-155,579	-155,579	0	-155,579	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-867,878	-867,878	0	-867,878	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,569	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		18,699,106	2.00
3.00	OPPS payments		15,032,761	3.00
4.00	Outlier payment (see instructions)		220,237	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		32,185	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,569	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		22,533	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)		22,533	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		22,533	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		15,964	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)		6,569	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)		15,285,183	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,701,037	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)		12,590,715	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		8,473	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)		12,599,188	30.00
31.00	Primary payer payments		848	31.00
32.00	Subtotal (line 30 minus line 31)		12,598,340	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)		338,728	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		220,173	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		237,682	36.00
37.00	Subtotal (see instructions)		12,818,513	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		12,818,513	40.00
40.01	Sequestration adjustment (see instructions)		256,370	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		12,494,682	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		67,461	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Subprovider - IRF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		232	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		261	2.00
3.00	OPPS payments		197	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		1	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		232	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		794	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)		794	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)		794	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		562	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)		232	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)		198	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)		24	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)		406	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)		406	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		406	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		406	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		406	40.00
40.01	Sequestration adjustment (see instructions)		8	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		341	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		57	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: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E-1
Part I
Date/Time Prepared:
11/28/2018 4:11 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		35,871,034		12,302,835	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		260,860		191,847	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		36,131,894		12,494,682	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		690,369		67,461	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		36,822,263		12,562,143	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0007 Component CCN: 14-T007		Period: From 01/01/2018 To 06/30/2018		Worksheet E-1 Part I Date/Time Prepared: 11/28/2018 4:11 am	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						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		8,718,773		341		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,718,773		341		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		57		6.01
6.02	SETTLEMENT TO PROGRAM		62,190		0		6.02
7.00	Total Medicare program liability (see instructions)		8,656,583		398		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet E-1
Part II
Date/Time Prepared:
11/28/2018 4:11 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0007 Component CCN: 14-T007	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part III Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8,706,402 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0105 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			161,939 3.00
4.00	Outlier Payments			34,760 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			36.104972 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			8,903,101 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			8,903,101 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			8,903,101 19.00
20.00	Deductibles			62,860 20.00
21.00	Subtotal (line 19 minus line 20)			8,840,241 21.00
22.00	Coinsurance			17,085 22.00
23.00	Subtotal (line 21 minus line 22)			8,823,156 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			5,360 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			3,484 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			5,360 26.00
27.00	Subtotal (sum of lines 23 and 25)			8,826,640 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			6,608 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			8,833,248 32.00
32.01	Sequestration adjustment (see instructions)			176,665 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			8,718,773 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-62,190 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			7,470 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			34,760 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

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 4:11 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			9.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			5.85	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			5.85	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			9.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.40	6.00
7.00	Enter the lesser of line 5 or line 6			1.40	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	1.40	1.40	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	1.40	1.40	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.42		10.01
11.00	Total weighted FTE count	0.00	1.40		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.47		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.47		17.00
18.00	Per resident amount	122,240.42	122,240.42		18.00
19.00	Approved amount for resident costs	0	57,453	57,453	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			57,453	25.00
		Inpatient Part	Managed care		
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	22,209	4,476		26.00
27.00	Total Inpatient Days (see instructions)	43,442	43,442		27.00
28.00	Ratio of inpatient days to total inpatient days	0.511233	0.103034		28.00
29.00	Program direct GME amount	29,372	5,920		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		836		30.00
31.00	Net Program direct GME amount			34,456	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Hospital	PPS
				1.00
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		4,082,085	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		57,477,393	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		14,320	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		57,463,073	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		18,738,354	42.00
43.00	Primary payer payments (see instructions)		848	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		18,737,506	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		76,200,579	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.754103	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.245897	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		34,456	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		25,983	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		8,473	50.00

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

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet G

Date/Time Prepared:

11/28/2018 4:11 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	4,641,631	0	0	0	1.00
2.00	Temporary investments	1,116,611	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	222,960,251	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-166,119,591	0	0	0	6.00
7.00	Inventory	9,500,290	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,185,709	0	0	0	9.00
10.00	Due from other funds	-2,329,236	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	72,955,665	0	0	0	11.00
FIXED ASSETS						
12.00	Land	7,950,000	0	0	0	12.00
13.00	Land improvements	1,188,596	0	0	0	13.00
14.00	Accumulated depreciation	-91,000	0	0	0	14.00
15.00	Buildings	92,256,381	0	0	0	15.00
16.00	Accumulated depreciation	-1,228,005	0	0	0	16.00
17.00	Leasehold improvements	3,702,142	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	24,289,788	0	0	0	23.00
24.00	Accumulated depreciation	-3,547,640	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)	124,520,262	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,484,218	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	113,849	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,598,067	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	199,073,994	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,247,224	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	13,191	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	43,510,539	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	46,770,954	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	728,055	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	728,055	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	47,499,009	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	151,574,985				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)	151,574,985	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	199,073,994	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet G-1

Date/Time Prepared:
11/28/2018 4:11 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		232,287,036		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-364,099				2.00
3.00	Total (sum of line 1 and line 2)		231,922,937		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NET ASSET TRANSFERS	3,238,935		0		0	5.00
6.00	OTHER UNRESTRICTED NET ASSETS	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		3,238,935		0		10.00
11.00	Subtotal (line 3 plus line 10)		235,161,872		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	OPENING BALANCE SHEET ADJUSTMENT	83,586,887		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		83,586,887		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		151,574,985		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	NET ASSET TRANSFERS		0				5.00
6.00	OTHER UNRESTRICTED NET ASSETS		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	OPENING BALANCE SHEET ADJUSTMENT		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: 14-0007

Period:
From 01/01/2018
To 06/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2018 4:11 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	107,413,663		107,413,663	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	18,068,710		18,068,710	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	125,482,373		125,482,373	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	22,410,183		22,410,183	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT	20,174,045		20,174,045	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	42,584,228		42,584,228	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	168,066,601		168,066,601	17.00
18.00	Ancillary services	356,895,842	398,596,388	755,492,230	18.00
19.00	Outpatient services	34,509,787	100,315,017	134,824,804	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	NON REIMBURSABLE	16,530	1,581,693	1,598,223	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	559,488,760	500,493,098	1,059,981,858	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		183,683,692		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	ROUNDING	1			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)		1		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)		183,683,693		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0007

Period:
From 01/01/2018
To 06/30/2018

Worksheet G-3

Date/Time Prepared:
11/28/2018 4:11 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,059,981,858	1.00
2.00	Less contractual allowances and discounts on patients' accounts	881,468,978	2.00
3.00	Net patient revenues (line 1 minus line 2)	178,512,880	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	183,683,693	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,170,813	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	532,317	6.00
7.00	Income from investments	-3,350	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	724,731	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	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ALL OTHERS	3,553,016	24.00
24.01	OTHER GAINS	0	24.01
25.00	Total other income (sum of lines 6-24)	4,806,714	25.00
26.00	Total (line 5 plus line 25)	-364,099	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)	-364,099	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0007	Period: From 01/01/2018 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/28/2018 4:11 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		2,873,438	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		29,919	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		203.91	3.00
4.00	Number of interns & residents (see instructions)		2.87	4.00
5.00	Indirect medical education percentage (see instructions)		0.40	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		11,494	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		22.91	8.00
9.00	Sum of lines 7 and 8		25.75	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.35	10.00
11.00	Disproportionate share adjustment (see instructions)		153,729	11.00
12.00	Total prospective capital payments (see instructions)		3,068,580	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00