

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: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/27/2019 2:29 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/27/2019	Time: 2:29 pm
	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 OTTAWA REGIONAL HOSPITAL & HEALTHCAR (14-0110) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 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)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-40,255	283,677	0	0	1.00
2.00	Subprovider - IPF	0	0	7		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-40,255	283,684	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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part I
Date/Time Prepared:
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1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1100 EAST NORRIS DRIVE			PO Box:						1.00	
2.00	City: OTTAWA			State: IL		Zip Code: 61350		County: LA SALLE		2.00	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
								V	XVIII	XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		OTTAWA REGIONAL HOSPITAL & HEALTHCARE		140110	99914	1	07/01/1966	N	P	O
4.00	Subprovider - IPF		OTTAWA REGIONAL PSYCHIATRIC UNIT		14S110	16974	4	05/01/1984	N	P	O
5.00	Subprovider - IRF										
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)							10/01/2017	09/30/2018		20.00
21.00	Type of Control (see instructions)							2			21.00
							1.00	2.00		3.00	
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		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N				23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
				1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,304	1,542	0	0	844	131		24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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Period:
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	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		
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
					Urban/Rural S	Date of Geogr		
					1.00	2.00		
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2						26.00	
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1 10/01/2015						27.00	
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0						35.00	
					Beginning:	Ending:		
					1.00	2.00		
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0						37.00	
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							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), (ii), or (iii)? 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), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y					Y	39.00	
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	Y					Y	40.00	
					V	XVIII	XIX	
					1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital								
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N					N	N	45.00
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N					N	N	46.00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N					N	N	47.00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N					N	N	48.00
Teaching Hospitals								
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N							56.00
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N							57.00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N							58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N							59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
				1.00	2.00	3.00		
60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N						60.00	

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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
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		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						0	76.00

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00
		V	XIX	
		1.00	2.00	
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 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.	N	N	N
				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: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 2:29 pm	
			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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1	-939,325		0
		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		Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0110		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 2:29 pm		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name: OSF HEALTHCARE SYSTEM		Contractor's Name: WPS		Contractor's Number: 00131				141.00	
142.00	Street: 800 N.E. GLEN OAK AVENUE		PO Box:						142.00	
143.00	City: PEORIA		State: IL		Zip Code: 61603				143.00	
								1.00		
144.00	Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				N				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.								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)						10/01/2017	09/30/2018	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: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 2:29 pm
			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)	N		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.	Y		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.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	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)	Y	12/17/2018	Y 12/17/2018
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		Y
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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICIA		RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544		PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-2
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR	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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	85	31,025	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)		85	31,025	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		90	32,850	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	7	2,555		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			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)		97			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,899	1,972	11,837			1.00
2.00	HMO and other (see instructions)	943	2,386				2.00
3.00	HMO IPF Subprovider	29	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,899	1,972	11,837			7.00
8.00	INTENSIVE CARE UNIT	573	175	998			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		157	895			13.00
14.00	Total (see instructions)	5,472	2,304	13,730	0.00	606.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	866	289	1,753	0.00	7.44	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	614.10	27.00
28.00	Observation Bed Days		441	2,029			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	131	186			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

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	1,558	729	4,069	1.00
2.00 HMO and other (see instructions)			250	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,558	729	4,069	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	155	57	343	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

		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	41,117,088	15,488	41,132,576	1,258,140.00	32.69	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		810,336	0	810,336	4,084.00	198.42	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		4,646,690	0	4,646,690	22,737.00	204.37	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		386,063	76,675	462,738	16,842.00	27.48	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,112,471	0	2,112,471	29,705.00	71.11	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		248,652	0	248,652	989.73	251.23	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		7,664,297	0	7,664,297	206,589.00	37.10	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)		9,757,388	0	9,757,388			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		132,872	0	132,872			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		98,761	0	98,761			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		562,724	0	562,724			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		2,402,148	0	2,402,148			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	-15,024	15,488	464	37.00	12.54	26.00
27.00	Administrative & General	5.00	2,569,122	0	2,569,122	95,053.00	27.03	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

		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.)		557,793	0	557,793	4,377.00	127.44	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,191,647	0	1,191,647	42,171.00	28.26	30.00
31.00	Laundry & Linen Service	8.00	29,879	0	29,879	2,080.00	14.36	31.00
32.00	Housekeeping	9.00	1,024,113	0	1,024,113	68,121.00	15.03	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	759,648	0	759,648	47,993.00	15.83	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	753,009	0	753,009	20,398.00	36.92	38.00
39.00	Central Services and Supply	14.00	54,688	0	54,688	4,183.00	13.07	39.00
40.00	Pharmacy	15.00	848,919	0	848,919	21,719.00	39.09	40.00
41.00	Medical Records & Medical Records Library	16.00	1,279,327	0	1,279,327	44,337.00	28.85	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part III
Date/Time Prepared:
2/27/2019 2:29 pm

	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)	37,028,191	15,488	37,043,679	1,239,780.00	29.88	1.00
2.00	Excluded area salaries (see instructions)	386,063	76,675	462,738	16,842.00	27.48	2.00
3.00	Subtotal salaries (line 1 minus line 2)	36,642,128	-61,187	36,580,941	1,222,938.00	29.91	3.00
4.00	Subtotal other wages & related costs (see inst.)	10,025,420	0	10,025,420	237,283.73	42.25	4.00
5.00	Subtotal wage-related costs (see inst.)	12,258,297	0	12,258,297	0.00	33.51	5.00
6.00	Total (sum of lines 3 thru 5)	58,925,845	-61,187	58,864,658	1,460,221.73	40.31	6.00
7.00	Total overhead cost (see instructions)	9,053,121	15,488	9,068,609	350,469.00	25.88	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2019 2:29 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,603,443 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			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)			6,144,064 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			0 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			360,070 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			2,316,941 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			127,227 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			10,551,745 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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet S-3
Part V
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,112,471	10,551,745	1.00
2.00	Hospital	2,112,471	10,551,745	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet S-10

Date/Time Prepared:
2/27/2019 2:29 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.213913	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		11,794,069	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		94,079,763	6.00
7.00	Medicaid cost (line 1 times line 6)		20,124,884	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)		8,330,815	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)		8,330,815	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)	6,200,037	1,405,819	7,605,856
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,326,269	1,405,819	2,732,088
22.00	Payments received from patients for amounts previously written off as charity care	39,532	0	39,532
23.00	Cost of charity care (line 21 minus line 22)	1,286,737	1,405,819	2,692,556
			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)		5,379,575	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		783,514	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,205,406	27.01
28.00	Non-Medicare bad debt expense (see instructions)		4,174,169	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,314,801	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		4,007,357	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		12,338,172	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/27/2019 2:29 pm

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		1,231,465	1,231,465	142,532	1,373,997
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,208,243	3,208,243	9,018	3,217,261
3.00	00300	OTHER CAP REL COSTS		0	0	0	0
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-15,024	10,653,061	10,638,037	1,652,687	12,290,724
5.00	00500	ADMINISTRATIVE & GENERAL	2,569,122	19,183,674	21,752,796	-2,963,316	18,789,480
7.00	00700	OPERATION OF PLANT	1,191,647	2,141,544	3,333,191	-167,634	3,165,557
8.00	00800	LAUNDRY & LINEN SERVICE	29,879	279,382	309,261	0	309,261
9.00	00900	HOUSEKEEPING	1,024,113	188,559	1,212,672	0	1,212,672
10.00	01000	DIETARY	759,648	610,610	1,370,258	0	1,370,258
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	753,009	38,119	791,128	0	791,128
14.00	01400	CENTRAL SERVICES & SUPPLY	54,688	-90,370	-35,682	-46,891	-82,573
15.00	01500	PHARMACY	848,919	5,257,618	6,106,537	-4,186,052	1,920,485
16.00	01600	MEDICAL RECORDS & LIBRARY	1,279,327	32,935	1,312,262	0	1,312,262
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,168,871	3,906,969	11,075,840	-2,337,578	8,738,262
31.00	03100	INTENSIVE CARE UNIT	885,974	237,889	1,123,863	0	1,123,863
40.00	04000	SUBPROVIDER - IPF	357,794	1,902	359,696	76,675	436,371
43.00	04300	NURSERY	0	0	0	271,758	271,758
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,222,478	3,377,246	4,599,724	-2,126,923	2,472,801
51.00	05100	RECOVERY ROOM	737,138	57,233	794,371	0	794,371
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,454,500	1,454,500
53.00	05300	ANESTHESIOLOGY	2,446,354	162,722	2,609,076	0	2,609,076
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,939,327	2,954,676	6,894,003	1,087,086	7,981,089
58.00	05800	MRI	296,541	44,052	340,593	4,568	345,161
60.00	06000	LABORATORY	2,095,845	2,232,343	4,328,188	204,786	4,532,974
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	907,353	272,338	1,179,691	-80,020	1,099,671
66.00	06600	PHYSICAL THERAPY	2,201,431	557,948	2,759,379	-303,298	2,456,081
67.00	06700	OCCUPATIONAL THERAPY	693,097	156,191	849,288	18,189	867,477
68.00	06800	SPEECH PATHOLOGY	147,228	4,348	151,576	8,842	160,418
69.00	06900	ELECTROCARDIOLOGY	0	0	0	179,430	179,430
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	4,516	4,516
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,426,928	2,426,928
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,460,166	1,460,166
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,338,724	4,338,724
75.00	07500	ASC (NON-DISTINCT PART)	1,719,278	975,668	2,694,946	-1,134,547	1,560,399
76.00	03160	STRESS TESTING	0	0	0	0	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,495,819	285,668	2,781,487	-58,468	2,723,019
76.02	03610	SLEEP LAB	151,668	13,204	164,872	0	164,872
76.97	07697	CARDIAC REHABILITATION	203,774	13,022	216,796	523,610	740,406
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,923,521	4,811,554	9,735,075	-222,035	9,513,040
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
117.00	06950	HOMEMAKER	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	41,088,819	62,799,813	103,888,632	237,253	104,125,885
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,269	40,402	68,671	0	68,671
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	728,452	728,452	-237,253	491,199
194.00	07950	CARDINAL SLEEP	0	0	0	0	0
194.01	07951	OTHER NRCC	0	61,079	61,079	0	61,079
200.00		TOTAL (SUM OF LINES 118 through 199)	41,117,088	63,629,746	104,746,834	0	104,746,834

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A

Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-733,111	640,886	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,179,616	5,396,877	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-24,253	12,266,471	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,591,339	14,198,141	5.00
7.00	00700	OPERATION OF PLANT	-426	3,165,131	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	309,261	8.00
9.00	00900	HOUSEKEEPING	0	1,212,672	9.00
10.00	01000	DIETARY	-341,580	1,028,678	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	481,461	1,272,589	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-82,573	14.00
15.00	01500	PHARMACY	0	1,920,485	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-16,562	1,295,700	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,153,000	6,585,262	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,123,863	31.00
40.00	04000	SUBPROVIDER - IPF	0	436,371	40.00
43.00	04300	NURSERY	0	271,758	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-61,538	2,411,263	50.00
51.00	05100	RECOVERY ROOM	0	794,371	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,454,500	52.00
53.00	05300	ANESTHESIOLOGY	-1,871,161	737,915	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-829,596	7,151,493	54.00
58.00	05800	MRI	0	345,161	58.00
60.00	06000	LABORATORY	-133,941	4,399,033	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,099,671	65.00
66.00	06600	PHYSICAL THERAPY	-177,965	2,278,116	66.00
67.00	06700	OCCUPATIONAL THERAPY	-617,460	250,017	67.00
68.00	06800	SPEECH PATHOLOGY	0	160,418	68.00
69.00	06900	ELECTROCARDIOLOGY	0	179,430	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	4,516	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,426,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,460,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,338,724	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,560,399	75.00
76.00	03160	STRESS TESTING	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-1,575,827	1,147,192	76.01
76.02	03610	SLEEP LAB	0	164,872	76.02
76.97	07697	CARDIAC REHABILITATION	0	740,406	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-5,087,609	4,425,431	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	0	116.00
117.00	06950	HOMEMAKER	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-15,554,291	88,571,594	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	68,671	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	491,199	192.00
194.00	07950	CARDINAL SLEEP	0	0	194.00
194.01	07951	OTHER NRCC	0	61,079	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-15,554,291	89,192,543	200.00

RECLASSIFICATIONS

Provider CCN: 14-0110

Period:
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To 09/30/2018

Worksheet A-6

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		Increases				
		Cost Center	Line #	Salary	Other	
		2.00	3.00	4.00	5.00	
	A - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00		0	68,444	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		0	9,018	2.00
	0			0	77,462	
	B - DELIVERY ROOM AND NURSERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00		1,202,468	554,453	1.00
2.00	NURSERY	43.00		185,996	85,762	2.00
	0			1,388,464	640,215	
	C - EKG HOLTER, STRESS, EEG					
1.00	ELECTROCARDIOLOGY	69.00		179,430	0	1.00
2.00	CARDIAC REHABILITATION	76.97		165,376	358,234	2.00
3.00	ELECTROENCEPHALOGRAPHY	70.00		4,516	0	3.00
	0			349,322	358,234	
	E - CLINICAL ENGINEERING					
1.00	LABORATORY	60.00		0	204,786	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00		0	1,092,769	2.00
	TOTALS			0	1,297,555	
	F - MINISTRY ALLOCATIONS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		0	1,652,687	1.00
2.00	OPERATION OF PLANT	7.00		0	245,015	2.00
3.00	PHARMACY	15.00		0	129,574	3.00
4.00	PHYSICAL THERAPY	66.00		0	76,199	4.00
5.00	OCCUPATIONAL THERAPY	67.00		0	23,453	5.00
6.00	SPEECH PATHOLOGY	68.00		0	4,186	6.00
	TOTALS			0	2,131,114	
	I - C-SECTION					
1.00	OPERATING ROOM	50.00		206,982	95,439	1.00
	0			206,982	95,439	
	M - MOB HOSPITAL STORAGE					
1.00	ADMINISTRATIVE & GENERAL	5.00		0	32,505	1.00
	0			0	32,505	
	O - PSYCH ADMIN					
1.00	SUBPROVIDER - IPF	40.00		76,675	0	1.00
2.00		0.00		0	0	2.00
	0			76,675	0	
	U - NORRIS BUILDING OVERHEAD					
1.00	OPERATION OF PLANT	7.00		0	22,534	1.00
2.00	SPEECH PATHOLOGY	68.00		0	4,656	2.00
3.00	ASC (NON-DISTINCT PART)	75.00		0	15,923	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00		0	76,258	4.00
	TOTALS			0	119,371	
	V - MERCURY CIRCLE BUILDING					
1.00	ADMINISTRATIVE & GENERAL	5.00		0	3,073	1.00
2.00	OPERATION OF PLANT	7.00		0	80,519	2.00
	0			0	83,592	
	W - RADIOLOGY SPACE					
1.00	RADIOLOGY-DIAGNOSTIC	54.00		0	1,785	1.00
	0			0	1,785	
	AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		0	2,426,928	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		0	1,460,166	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00		0	4,338,724	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00		0	1,396	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
	0			0	8,227,214	
	AC - NEGATIVE SALARIES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		15,488	0	1.00
	TOTALS			15,488	0	

RECLASSIFICATIONS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

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	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
1.00	AD - MRI SALARIES				1.00
	MRI	58.00	3,301	1,267	
	0		3,301	1,267	
1.00	AE - STREATOR EXPENSES				1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	74,088	
	OPERATION OF PLANT	7.00	0	781,853	
2.00	0		0	855,941	2.00
500.00	Grand Total: Increases		2,040,232	13,921,694	500.00

RECLASSIFICATIONS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

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	Decreases						2/27/2019 2:29 PM
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	77,462	12		1.00
2.00	0	0.00	0	0	12		2.00
	0		0	77,462			
	B - DELIVERY ROOM AND NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	1,388,464	640,215	0		1.00
2.00	0	0.00	0	0	0		2.00
	0		1,388,464	640,215			
	C - EKG HOLTER, STRESS,EEG						
1.00	ASC (NON-DISTINCT PART)	75.00	349,322	358,234	0		1.00
2.00	0	0.00	0	0	0		2.00
3.00	0	0.00	0	0	0		3.00
	0		349,322	358,234			
	E - CLINICAL ENGINEERING						
1.00	OPERATION OF PLANT	7.00	0	1,297,555	0		1.00
2.00	0	0.00	0	0	0		2.00
	TOTALS		0	1,297,555			
	F - MINISTRY ALLOCATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,131,114	0		1.00
2.00	0	0.00	0	0	0		2.00
3.00	0	0.00	0	0	0		3.00
4.00	0	0.00	0	0	0		4.00
5.00	0	0.00	0	0	0		5.00
6.00	0	0.00	0	0	0		6.00
	TOTALS		0	2,131,114			
	I - C-SECTION						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	206,982	95,439	0		1.00
	0		206,982	95,439			
	M - MOB HOSPITAL STORAGE						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	32,505	0		1.00
	0		0	32,505			
	O - PSYCH ADMIN						
1.00	ADULTS & PEDIATRICS	30.00	18,207	0	0		1.00
2.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01	58,468	0	0		2.00
	0		76,675	0			
	U - NORRIS BUILDING OVERHEAD						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	119,371	0		1.00
2.00	0	0.00	0	0	0		2.00
3.00	0	0.00	0	0	0		3.00
4.00	0	0.00	0	0	0		4.00
	TOTALS		0	119,371			
	V - MERCURY CIRCLE BUILDING						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	83,592	0		1.00
2.00	0	0.00	0	0	0		2.00
	0		0	83,592			
	W - RADIOLOGY SPACE						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,785	0		1.00
	0		0	1,785			
	AB - MED SUPPLIES SOLD IMPLANTS AND DRUGS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	10,740	0		1.00
2.00	PHARMACY	15.00	0	13,469	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	290,692	0		3.00
4.00	OPERATING ROOM	50.00	0	1,262,828	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	80,020	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	180,422	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	5,264	0		7.00
8.00	ASC (NON-DISTINCT PART)	75.00	0	361,458	0		8.00
9.00	EMERGENCY	91.00	0	222,035	0		9.00
10.00	ADMINISTRATIVE & GENERAL	5.00	0	10,635	0		10.00
11.00	PHARMACY	15.00	0	980	0		11.00
12.00	OPERATING ROOM	50.00	0	1,166,516	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,900	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	199,075	0		14.00
15.00	ASC (NON-DISTINCT PART)	75.00	0	81,456	0		15.00
16.00	CENTRAL SERVICES & SUPPLY	14.00	0	37,547	0		16.00
17.00	PHARMACY	15.00	0	4,301,177	0		17.00
	0		0	8,227,214			
	AC - NEGATIVE SALARIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15,488	0		1.00
	TOTALS		0	15,488			

RECLASSIFICATIONS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-6

Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
AD - MRI SALARIES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	3,301	1,267	0	1.00
	0		3,301	1,267		
AE - STREATOR EXPENSES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	855,941	9	1.00
2.00		0.00	0	0	0	2.00
	0		0	855,941		
500.00	Grand Total: Decreases		2,024,744	13,937,182		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

		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	3,227,906	0	0	0	0	1.00	
2.00	Land Improvements	2,987,640	-169,606	0	-169,606	0	2.00	
3.00	Buildings and Fixtures	82,800,019	-15,779,805	0	-15,779,805	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	10,706,095	-2,169,154	0	-2,169,154	0	6.00	
7.00	HIT designated Assets	-8,270,599	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	91,451,061	-18,118,565	0	-18,118,565	0	8.00	
9.00	Reconciling Items	0	266,342	0	266,342	0	9.00	
10.00	Total (line 8 minus line 9)	91,451,061	-18,384,907	0	-18,384,907	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	3,227,906	0				1.00	
2.00	Land Improvements	2,818,034	0				2.00	
3.00	Buildings and Fixtures	67,020,214	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	8,536,941	0				6.00	
7.00	HIT designated Assets	-8,270,599	0				7.00	
8.00	Subtotal (sum of lines 1-7)	73,332,496	0				8.00	
9.00	Reconciling Items	266,342	0				9.00	
10.00	Total (line 8 minus line 9)	73,066,154	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,163,021	0	0	68,444	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,199,225	0	0	9,018	0	2.00
3.00	Total (sum of lines 1-2)	4,362,246	0	0	77,462	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,231,465				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,208,243				2.00
3.00	Total (sum of lines 1-2)	0	4,439,708				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet A-7
Part III
Date/Time Prepared:
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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	64,795,555	0	64,795,555	0.883586	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,536,941	0	8,536,941	0.116414	0	2.00
3.00	Total (sum of lines 1-2)	73,332,496	0	73,332,496	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	291,789	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	4,752,252	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	5,044,041	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	212,209	136,888	0	0	640,886	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	626,589	18,036	0	0	5,396,877	2.00
3.00	Total (sum of lines 1-2)	838,798	154,924	0	0	6,037,763	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
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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	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-59,827	ADMINISTRATIVE & GENERAL	5.00	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	-11,999,046			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	1,583,278			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-341,580	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-993	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	AMORTIZED CAPITALIZED INTEREST	A	-27,171	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8

Date/Time Prepared:
2/27/2019 2:29 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.01 PHYSICIAN RECRUITING EXPENSE	A	-21,588	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02 PHYSICIAN RECRUITING EXPENSE	A	-176,844	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 PHYSICIAN RECRUITING EXPENSE	A	-2,665	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04 TRUSTEE FEES	A	9,122	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 ADMINISTRATION ALCOHOL	A	-631	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 ADVERTISING	A	-290	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 AHA LOBBYING FEES	A	-3,837	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 IHA LOBBYING FEES	A	-26,429	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 PATIENT TRANSPORTATION	A	-8,289	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 ROTARY FEES	A	-240	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 MEDICAID TAX ASSESSMENT - APPEAL	A	-3,146,293	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12 COMMUNITY EDUCATION REVENUE	B	-70	ADULTS & PEDIATRICS	30.00	0	33.12
33.13 MISCELLANEOUS REVENUE	B	-725,896	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14 MISCELLANEOUS REVENUE	B	-145,095	PHYSICAL THERAPY	66.00	0	33.14
33.15 INTEREST/INVESTMENT INCOME OFFSET	B	-1,133	CAP REL COSTS-BLDG & FIXT	1.00	11	33.15
33.16 CLINICAL LAB OTHER REVENUE	B	-13,984	LABORATORY	60.00	0	33.16
33.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.17
33.18 MISCELLANEOUS REVENUE	B	-396,854	OCCUPATIONAL THERAPY	67.00	0	33.18
33.19 MISCELLANEOUS REVENUE	B	-250	EMERGENCY	91.00	0	33.19
33.20 MISCELLANEOUS REVENUE	B	-426	OPERATION OF PLANT	7.00	0	33.20
33.21 COMMUNITY EDUCATION REVENUE	B	-15,391	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22 ADVERTISING	A	-603	ADULTS & PEDIATRICS	30.00	0	33.22
33.23 DONATIONS	A	-31,750	ADMINISTRATIVE & GENERAL	5.00	0	33.23
33.24 NURSING MISC	A	484	NURSING ADMINISTRATION	13.00	0	33.24
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-15,554,291				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: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-1

Date/Time Prepared:
2/27/2019 2:29 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	354,404	1,299,724 1.00
2.00		2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	1,553,027	0 2.00
3.00		5.00	ADMINISTRATIVE & GENERAL	HO POOLED - ADMIN & GENERAL	6,095,567	12,486,272 3.00
3.01		4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	1,652,687	1,652,687 3.01
3.02		7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	245,015	245,015 3.02
3.03		31.00	INTENSIVE CARE UNIT	MINISTRY ALLOCATION	116,428	116,428 3.03
3.04		66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	76,199	76,199 3.04
3.05		67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	23,453	23,453 3.05
3.06		68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	4,186	4,186 3.06
3.07		15.00	PHARMACY	MINISTRY ALLOCATION	581,137	581,137 3.07
4.00		1.00	CAP REL COSTS-BLDG & FIXT	HO INTEREST (OPERATING)	240,513	0 4.00
4.01		2.00	CAP REL COSTS-MVBLE EQUIP	HO INTEREST (OPERATING)	626,589	0 4.01
4.02		13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADMI	480,977	0 4.02
4.03		5.00	ADMINISTRATIVE & GENERAL	HO FUNCTIONAL - ADMIN & GEN	6,029,870	0 4.03
4.04		5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SFI	176,628	188,301 4.04
5.00			TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.		18,256,680	16,673,402 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	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	B		0.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-1

Date/Time Prepared:
2/27/2019 2:29 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-945,320	9		1.00
2.00	1,553,027	9		2.00
3.00	-6,390,705	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
4.00	240,513	11		4.00
4.01	626,589	11		4.01
4.02	480,977	0		4.02
4.03	6,029,870	0		4.03
4.04	-11,673	0		4.04
5.00	1,583,278			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	HOME OFFICE		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: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet A-8-2

Date/Time Prepared:
2/27/2019 2:29 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	116,531	0	116,531	211,500	829	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	67,427	0	67,427	211,500	510	2.00
3.00	30.00	ADULTS & PEDIATRICS	2,179,680	2,149,680	30,000	211,500	269	3.00
4.00	50.00	OPERATING ROOM	61,538	61,538	0	246,400	0	4.00
5.00	53.00	ANESTHESIOLOGY	2,025,735	1,700,211	325,524	239,400	1,343	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	829,596	829,596	0	271,900	0	6.00
7.00	60.00	LABORATORY	119,957	119,957	0	260,300	0	7.00
8.00	66.00	PHYSICAL THERAPY	46,800	0	46,800	211,500	137	8.00
9.00	67.00	OCCUPATIONAL THERAPY	220,606	220,606	0	211,500	0	9.00
10.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,600,233	1,553,173	47,060	181,300	280	10.00
11.00	91.00	EMERGENCY	5,260,830	4,835,184	425,646	211,500	1,706	11.00
200.00			12,528,933	11,469,945	1,058,988		5,074	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	84,295	4,215	0	0	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	51,858	2,593	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	27,353	1,368	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	154,574	7,729	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	13,930	697	0	0	0	8.00
9.00	67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	9.00
10.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,406	1,220	0	0	0	10.00
11.00	91.00	EMERGENCY	173,471	8,674	0	0	0	11.00
200.00			529,887	26,496	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	84,295	32,236	32,236		1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	51,858	15,569	15,569		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	27,353	2,647	2,152,327		3.00
4.00	50.00	OPERATING ROOM	0	0	0	61,538		4.00
5.00	53.00	ANESTHESIOLOGY	0	154,574	170,950	1,871,161		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	829,596		6.00
7.00	60.00	LABORATORY	0	0	0	119,957		7.00
8.00	66.00	PHYSICAL THERAPY	0	13,930	32,870	32,870		8.00
9.00	67.00	OCCUPATIONAL THERAPY	0	0	0	220,606		9.00
10.00	76.01	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	24,406	22,654	1,575,827		10.00
11.00	91.00	EMERGENCY	0	173,471	252,175	5,087,359		11.00
200.00			0	529,887	529,101	11,999,046		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	640,886	640,886			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,396,877		5,396,877		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,266,471	5,695	609	12,272,775	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,198,141	60,515	2,506,293	766,559	5.00
7.00	00700	OPERATION OF PLANT	3,165,131	202,082	23,328	355,556	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	309,261	2,539	0	8,915	8.00
9.00	00900	HOUSEKEEPING	1,212,672	3,832	13,052	305,569	9.00
10.00	01000	DIETARY	1,028,678	21,419	52,863	226,659	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,272,589	5,657	81,589	224,678	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-82,573	12,650	87,647	16,317	14.00
15.00	01500	PHARMACY	1,920,485	3,275	53,427	253,295	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,295,700	10,555	2,418	381,718	16.00
17.00	01700	SOCIAL SERVICE	0	1,892	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,319	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,585,262	48,901	230,594	1,768,958	30.00
31.00	03100	INTENSIVE CARE UNIT	1,123,863	5,188	39,156	264,352	31.00
40.00	04000	SUBPROVIDER - IPF	436,371	19,533	835	112,235	40.00
43.00	04300	NURSERY	271,758	0	0	62,813	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,411,263	18,675	563,853	416,743	50.00
51.00	05100	RECOVERY ROOM	794,371	2,003	0	219,943	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,454,500	0	0	276,647	52.00
53.00	05300	ANESTHESIOLOGY	737,915	0	70,044	728,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,151,493	41,001	612,823	1,172,462	54.00
58.00	05800	MRI	345,161	5,684	0	91,411	58.00
60.00	06000	LABORATORY	4,399,033	31,620	176,982	625,346	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,099,671	4,991	25,850	270,731	65.00
66.00	06600	PHYSICAL THERAPY	2,278,116	47,388	94,276	656,850	66.00
67.00	06700	OCCUPATIONAL THERAPY	250,017	6,758	0	206,802	67.00
68.00	06800	SPEECH PATHOLOGY	160,418	1,294	2	43,929	68.00
69.00	06900	ELECTROCARDIOLOGY	179,430	0	0	47,242	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,516	0	0	1,206	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,426,928	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,460,166	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,338,724	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,560,399	29,130	280,364	422,220	75.00
76.00	03160	STRESS TESTING	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,147,192	8,063	8,483	717,831	76.01
76.02	03610	SLEEP LAB	164,872	0	43,440	45,254	76.02
76.97	07697	CARDIAC REHABILITATION	740,406	0	0	103,120	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	4,425,431	38,419	46,195	1,469,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,571,594	638,759	5,014,123	12,264,340	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	68,671	2,127	0	8,435	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	491,199	0	382,754	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	194.00
194.01	07951	OTHER NRCC	61,079	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,192,543	640,886	5,396,877	12,272,775	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,531,508					5.00
7.00	00700	OPERATION OF PLANT	916,464	4,662,561				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	78,461	31,769	430,945			8.00
9.00	00900	HOUSEKEEPING	375,561	47,958	0	1,958,644		9.00
10.00	01000	DIETARY	325,285	268,036	0	125,935	2,048,875	10.00
11.00	01100	CAFETERIA	0	0	0	0	1,452,483	11.00
13.00	01300	NURSING ADMINISTRATION	387,643	70,785	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,328	158,302	0	12,721	0	14.00
15.00	01500	PHARMACY	545,676	40,981	0	35,618	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	413,546	132,088	0	38,162	0	16.00
17.00	01700	SOCIAL SERVICE	463	23,674	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	323	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,112,195	611,940	164,939	285,028	486,942	30.00
31.00	03100	INTENSIVE CARE UNIT	350,468	64,926	15,162	47,915	24,256	31.00
40.00	04000	SUBPROVIDER - IPF	139,197	244,430	3,644	121,270	85,194	40.00
43.00	04300	NURSERY	81,851	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	834,370	233,694	18,506	114,062	0	50.00
51.00	05100	RECOVERY ROOM	248,637	25,063	0	16,961	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	423,516	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	375,914	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,196,362	513,076	21,482	326,496	0	54.00
58.00	05800	MRI	108,196	71,124	0	2,544	0	58.00
60.00	06000	LABORATORY	1,280,223	395,687	0	97,525	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	342,807	62,454	0	43,250	0	65.00
66.00	06600	PHYSICAL THERAPY	752,682	593,006	44,422	216,251	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,412	84,570	0	17,809	0	67.00
68.00	06800	SPEECH PATHOLOGY	50,310	16,189	0	19,505	0	68.00
69.00	06900	ELECTROCARDIOLOGY	55,454	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,400	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	593,736	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	357,222	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,061,447	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	560,754	364,528	75,346	124,663	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	460,316	100,895	0	83,956	0	76.01
76.02	03610	SLEEP LAB	62,034	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	206,364	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	1,462,756	480,765	87,444	218,796	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	17,283,373	4,635,940	430,945	1,948,467	2,048,875	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,384	26,621	0	10,177	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	213,808	0	0	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	14,943	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	17,531,508	4,662,561	430,945	1,958,644	2,048,875	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	1,452,483					11.00
13.00	01300	NURSING ADMINISTRATION	30,609	2,073,550				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,997	14,859	234,248			14.00
15.00	01500	PHARMACY	31,833	78,811	0	2,963,401		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,067	161,146	357	0	2,500,757	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	305,914	757,603	11,125	0	123,800	30.00
31.00	03100	INTENSIVE CARE UNIT	36,009	89,176	1,960	0	24,760	31.00
40.00	04000	SUBPROVIDER - IPF	22,196	54,972	55	0	24,760	40.00
43.00	04300	NURSERY	7,846	19,449	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	67,484	167,135	17,363	0	173,320	50.00
51.00	05100	RECOVERY ROOM	29,685	73,507	1,988	0	24,760	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,036	104,107	0	0	49,520	52.00
53.00	05300	ANESTHESIOLOGY	20,734	0	3,477	0	74,280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	180,315	0	30,014	0	618,998	54.00
58.00	05800	MRI	13,127	0	1,151	0	74,280	58.00
60.00	06000	LABORATORY	127,658	0	9,991	0	420,919	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	44,005	0	2,620	0	49,520	65.00
66.00	06600	PHYSICAL THERAPY	89,620	0	4,692	0	99,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,115	0	165	0	24,760	67.00
68.00	06800	SPEECH PATHOLOGY	5,460	0	105	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,264	0	0	0	24,760	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	209	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	88,407	0	123,800	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	48,343	0	49,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,963,401	173,320	73.00
75.00	07500	ASC (NON-DISTINCT PART)	63,098	156,258	6,804	0	99,040	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	55,968	0	850	0	24,760	76.01
76.02	03610	SLEEP LAB	8,443	0	304	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	17,841	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	160,117	396,527	4,090	0	222,840	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,447,650	2,073,550	233,861	2,963,401	2,500,757	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,790	0	302	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,043	0	85	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,452,483	2,073,550	234,248	2,963,401	2,500,757	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
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Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	26,029					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,642				19.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0		0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,289	0	0	13,494,490	0	30.00
31.00	03100	INTENSIVE CARE UNIT	258	0	0	2,087,449	0	31.00
40.00	04000	SUBPROVIDER - IPF	258	0	0	1,264,950	0	40.00
43.00	04300	NURSERY	0	0	0	443,717	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,804	0	0	5,038,272	0	50.00
51.00	05100	RECOVERY ROOM	258	0	0	1,437,176	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	515	0	0	2,350,841	0	52.00
53.00	05300	ANESTHESIOLOGY	773	1,642	0	2,013,388	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,442	0	0	12,870,964	0	54.00
58.00	05800	MRI	773	0	0	713,451	0	58.00
60.00	06000	LABORATORY	4,381	0	0	7,569,365	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	515	0	0	1,946,414	0	65.00
66.00	06600	PHYSICAL THERAPY	1,031	0	0	4,877,374	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	258	0	0	712,666	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	297,212	0	68.00
69.00	06900	ELECTROCARDIOLOGY	258	0	0	315,408	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,331	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,289	0	0	3,234,160	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	515	0	0	1,915,766	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,804	0	0	8,538,696	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,031	0	0	3,743,635	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	258	0	0	2,608,572	0	76.01
76.02	03610	SLEEP LAB	0	0	0	324,347	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	1,067,731	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	2,319	0	0	9,014,750	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	26,029	1,642	0	87,888,125	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	137,507	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,090,889	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	76,022	0	194.01
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)	26,029	1,642	0	89,192,543	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03160	STRESS TESTING	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
76.02	03610	SLEEP LAB	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
117.00	06950	HOMEMAKER	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	CARDINAL SLEEP	194.00
194.01	07951	OTHER NRCC	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

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	5,695	609	6,304	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	60,515	2,506,293	2,566,808	5.00
7.00	00700	OPERATION OF PLANT	0	202,082	23,328	225,410	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,539	0	2,539	8.00
9.00	00900	HOUSEKEEPING	0	3,832	13,052	16,884	9.00
10.00	01000	DIETARY	0	21,419	52,863	74,282	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,657	81,589	87,246	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,650	87,647	100,297	14.00
15.00	01500	PHARMACY	0	3,275	53,427	56,702	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,555	2,418	12,973	16.00
17.00	01700	SOCIAL SERVICE	0	1,892	0	1,892	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	48,901	230,594	279,495	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,188	39,156	44,344	31.00
40.00	04000	SUBPROVIDER - IPF	0	19,533	835	20,368	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	18,675	563,853	582,528	50.00
51.00	05100	RECOVERY ROOM	0	2,003	0	2,003	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	70,044	70,044	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,001	612,823	653,824	54.00
58.00	05800	MRI	0	5,684	0	5,684	58.00
60.00	06000	LABORATORY	0	31,620	176,982	208,602	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,991	25,850	30,841	65.00
66.00	06600	PHYSICAL THERAPY	0	47,388	94,276	141,664	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,758	0	6,758	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,294	2	1,296	68.00
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	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	29,130	280,364	309,494	75.00
76.00	03160	STRESS TESTING	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	8,063	8,483	16,546	76.01
76.02	03610	SLEEP LAB	0	0	43,440	43,440	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	38,419	46,195	84,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	638,759	5,014,123	5,652,882	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,127	0	2,127	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	382,754	382,754	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	194.01
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	640,886	5,396,877	6,037,763	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,567,201					5.00
7.00	00700	OPERATION OF PLANT	134,200	359,792				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,489	2,451	16,484			8.00
9.00	00900	HOUSEKEEPING	54,994	3,701	0	75,736		9.00
10.00	01000	DIETARY	47,632	20,683	0	4,870	147,583	10.00
11.00	01100	CAFETERIA	0	0	0	0	104,624	11.00
13.00	01300	NURSING ADMINISTRATION	56,764	5,462	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,219	12,216	0	492	0	14.00
15.00	01500	PHARMACY	79,905	3,162	0	1,377	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,557	10,193	0	1,476	0	16.00
17.00	01700	SOCIAL SERVICE	68	1,827	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	47	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	309,294	47,222	6,309	11,021	35,075	30.00
31.00	03100	INTENSIVE CARE UNIT	51,320	5,010	580	1,853	1,747	31.00
40.00	04000	SUBPROVIDER - IPF	20,383	18,862	139	4,689	6,137	40.00
43.00	04300	NURSERY	11,986	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	122,179	18,033	708	4,410	0	50.00
51.00	05100	RECOVERY ROOM	36,409	1,934	0	656	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	62,017	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	55,046	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	321,639	39,592	822	12,626	0	54.00
58.00	05800	MRI	15,843	5,488	0	98	0	58.00
60.00	06000	LABORATORY	187,466	30,534	0	3,771	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	50,198	4,819	0	1,672	0	65.00
66.00	06600	PHYSICAL THERAPY	110,217	45,760	1,699	8,362	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	16,607	6,526	0	689	0	67.00
68.00	06800	SPEECH PATHOLOGY	7,367	1,249	0	754	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,120	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	205	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	86,942	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	52,309	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	155,430	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	82,113	28,129	2,882	4,820	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	67,405	7,786	0	3,246	0	76.01
76.02	03610	SLEEP LAB	9,084	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	30,218	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	214,195	37,099	3,345	8,460	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,530,867	357,738	16,484	75,342	147,583	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,838	2,054	0	394	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,308	0	0	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	2,188	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,567,201	359,792	16,484	75,736	147,583	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			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
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	104,624					11.00
13.00	01300	NURSING ADMINISTRATION	2,205	151,792				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	432	1,088	85,584			14.00
15.00	01500	PHARMACY	2,293	5,769	0	149,338		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,687	11,796	130	0	102,008	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	22,036	55,460	4,065	0	5,050	30.00
31.00	03100	INTENSIVE CARE UNIT	2,594	6,528	716	0	1,010	31.00
40.00	04000	SUBPROVIDER - IPF	1,599	4,024	20	0	1,010	40.00
43.00	04300	NURSERY	565	1,424	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,861	12,235	6,344	0	7,070	50.00
51.00	05100	RECOVERY ROOM	2,138	5,381	726	0	1,010	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,028	7,621	0	0	2,020	52.00
53.00	05300	ANESTHESIOLOGY	1,494	0	1,270	0	3,030	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,988	0	10,966	0	25,248	54.00
58.00	05800	MRI	946	0	420	0	3,030	58.00
60.00	06000	LABORATORY	9,195	0	3,650	0	17,170	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,170	0	957	0	2,020	65.00
66.00	06600	PHYSICAL THERAPY	6,455	0	1,714	0	4,040	66.00
67.00	06700	OCCUPATIONAL THERAPY	585	0	60	0	1,010	67.00
68.00	06800	SPEECH PATHOLOGY	393	0	38	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	595	0	0	0	1,010	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	32,302	0	5,050	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	17,663	0	2,020	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	149,338	7,070	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,545	11,439	2,486	0	4,040	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,031	0	311	0	1,010	76.01
76.02	03610	SLEEP LAB	608	0	111	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	1,285	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	11,533	29,027	1,494	0	9,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	104,276	151,792	85,443	149,338	102,008	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	129	0	110	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	219	0	31	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	30,168	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	104,624	151,792	115,752	149,338	102,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			17.00	19.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	3,787					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	48				19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0		0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	187			776,129	0	30.00
31.00	03100	INTENSIVE CARE UNIT	37			115,875	0	31.00
40.00	04000	SUBPROVIDER - IPF	37			77,326	0	40.00
43.00	04300	NURSERY	0			14,007	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	262			758,844	0	50.00
51.00	05100	RECOVERY ROOM	37			50,407	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	75			74,903	0	52.00
53.00	05300	ANESTHESIOLOGY	112			131,370	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	944			1,079,250	0	54.00
58.00	05800	MRI	112			31,668	0	58.00
60.00	06000	LABORATORY	637			461,346	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0			0	0	64.00
65.00	06500	RESPIRATORY THERAPY	75			93,891	0	65.00
66.00	06600	PHYSICAL THERAPY	150			320,398	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	37			32,378	0	67.00
68.00	06800	SPEECH PATHOLOGY	0			11,120	0	68.00
69.00	06900	ELECTROCARDIOLOGY	37			9,786	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0			221	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	187			124,481	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75			72,067	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	262			312,100	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	150			450,315	0	75.00
76.00	03160	STRESS TESTING	0			0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	37			100,740	0	76.01
76.02	03610	SLEEP LAB	0			53,266	0	76.02
76.97	07697	CARDIAC REHABILITATION	0			31,556	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	337			399,947	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0			0	0	116.00
117.00	06950	HOMEMAKER	0			0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,787	0	0	5,583,391	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			7,656	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0			414,312	0	192.00
194.00	07950	CARDINAL SLEEP	0			0	0	194.00
194.01	07951	OTHER NRCC	0			2,188	0	194.01
200.00		Cross Foot Adjustments		48	0	48	0	200.00
201.00		Negative Cost Centers	0	0	0	30,168	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,787	48	0	6,037,763	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet B
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03160	STRESS TESTING	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.01
76.02	03610	SLEEP LAB	76.02
76.97	07697	CARDIAC REHABILITATION	76.97
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
116.00	11600	HOSPICE	116.00
117.00	06950	HOMEMAKER	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	CARDINAL SLEEP	194.00
194.01	07951	OTHER NRCC	194.01
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

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	236,794					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,011,008				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,104	340	41,132,122			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,359	1,398,302	2,569,122	-17,531,508	71,661,035	5.00
7.00	00700	OPERATION OF PLANT	74,665	13,015	1,191,647	0	3,746,097	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	938	0	29,879	0	320,715	8.00
9.00	00900	HOUSEKEEPING	1,416	7,282	1,024,113	0	1,535,125	9.00
10.00	01000	DIETARY	7,914	29,493	759,648	0	1,329,619	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,090	45,520	753,009	0	1,584,513	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,674	48,900	54,688	0	34,041	14.00
15.00	01500	PHARMACY	1,210	29,808	848,919	0	2,230,482	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,900	1,349	1,279,327	0	1,690,391	16.00
17.00	01700	SOCIAL SERVICE	699	0	0	0	1,892	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	4,421	0	1,319	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,068	128,652	5,928,591	0	8,633,715	30.00
31.00	03100	INTENSIVE CARE UNIT	1,917	21,846	885,974	0	1,432,559	31.00
40.00	04000	SUBPROVIDER - IPF	7,217	466	376,157	0	568,974	40.00
43.00	04300	NURSERY	0	0	210,516	0	334,571	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,900	314,583	1,396,714	0	3,410,534	50.00
51.00	05100	RECOVERY ROOM	740	0	737,138	0	1,016,317	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	927,183	0	1,731,147	52.00
53.00	05300	ANESTHESIOLOGY	0	39,079	2,441,933	0	1,536,568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,149	341,904	3,929,505	0	8,977,779	54.00
58.00	05800	MRI	2,100	0	306,363	0	442,256	58.00
60.00	06000	LABORATORY	11,683	98,741	2,095,845	0	5,232,981	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,844	14,422	907,353	0	1,401,243	65.00
66.00	06600	PHYSICAL THERAPY	17,509	52,598	2,201,431	0	3,076,630	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,497	0	693,097	0	463,577	67.00
68.00	06800	SPEECH PATHOLOGY	478	1	147,228	0	205,643	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	158,333	0	226,672	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	4,043	0	5,722	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,426,928	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,460,166	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,338,724	73.00
75.00	07500	ASC (NON-DISTINCT PART)	10,763	156,420	1,415,069	0	2,292,113	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,979	4,733	2,405,811	0	1,881,569	76.01
76.02	03610	SLEEP LAB	0	24,236	151,668	0	253,566	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	345,607	0	843,526	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	14,195	25,773	4,923,521	0	5,979,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	236,008	2,797,463	41,103,853	-17,531,508	70,646,770	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	0	28,269	0	79,233	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	213,545	0	0	873,953	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	61,079	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	640,886	5,396,877	12,272,775		17,531,508	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.706513	1.792382	0.298374		0.244645	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			6,304		2,567,201	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000153		0.035824	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

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	
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: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	137,666				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	938	549,255			8.00
9.00	00900	HOUSEKEEPING	1,416	0	46,192		9.00
10.00	01000	DIETARY	7,914	0	2,970	129,915	10.00
11.00	01100	CAFETERIA	0	0	0	92,099	11.00
13.00	01300	NURSING ADMINISTRATION	2,090	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,674	0	300	0	14.00
15.00	01500	PHARMACY	1,210	0	840	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,900	0	900	0	16.00
17.00	01700	SOCIAL SERVICE	699	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	18,068	210,222	6,722	30,876	30.00
31.00	03100	INTENSIVE CARE UNIT	1,917	19,325	1,130	1,538	31.00
40.00	04000	SUBPROVIDER - IPF	7,217	4,644	2,860	5,402	40.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,900	23,586	2,690	0	50.00
51.00	05100	RECOVERY ROOM	740	0	400	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,149	27,379	7,700	0	54.00
58.00	05800	MRI	2,100	0	60	0	58.00
60.00	06000	LABORATORY	11,683	0	2,300	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,844	0	1,020	0	65.00
66.00	06600	PHYSICAL THERAPY	17,509	56,617	5,100	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,497	0	420	0	67.00
68.00	06800	SPEECH PATHOLOGY	478	0	460	0	68.00
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	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	10,763	96,031	2,940	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,979	0	1,980	0	76.01
76.02	03610	SLEEP LAB	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	14,195	111,451	5,160	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	136,880	549,255	45,952	129,915	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	786	0	240	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	194.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,662,561	430,945	1,958,644	2,048,875	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.868646	0.784599	42.402234	15.770889	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	359,792	16,484	75,736	147,583	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.613514	0.030012	1.639591	1.135997	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES SERVED)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	7.00	8.00	9.00	10.00	11.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			NURSING ADMINISTRATION (HOURS SUPPLIED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	583,724					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,183	5,935,275				14.00
15.00	01500	PHARMACY	22,186	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	45,364	9,042	0	101		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	101	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	213,273	281,871	0	5	5	30.00
31.00	03100	INTENSIVE CARE UNIT	25,104	49,659	0	1	1	31.00
40.00	04000	SUBPROVIDER - IPF	15,475	1,385	0	1	1	40.00
43.00	04300	NURSERY	5,475	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,050	439,946	0	7	7	50.00
51.00	05100	RECOVERY ROOM	20,693	50,367	0	1	1	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,307	0	0	2	2	52.00
53.00	05300	ANESTHESIOLOGY	0	88,094	0	3	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	760,487	0	25	25	54.00
58.00	05800	MRI	0	29,151	0	3	3	58.00
60.00	06000	LABORATORY	0	253,143	0	17	17	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	66,392	0	2	2	65.00
66.00	06600	PHYSICAL THERAPY	0	118,896	0	4	4	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,189	0	1	1	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,663	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1	1	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,239,991	0	5	5	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,224,908	0	2	2	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	7	7	73.00
75.00	07500	ASC (NON-DISTINCT PART)	43,988	172,397	0	4	4	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	21,539	0	1	1	76.01
76.02	03610	SLEEP LAB	0	7,714	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	111,626	103,638	0	9	9	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
117.00	06950	HOMEMAKER	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	583,724	5,925,472	100	101	101	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,649	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,154	0	0	0	192.00
194.00	07950	CARDINAL SLEEP	0	0	0	0	0	194.00
194.01	07951	OTHER NRCC	0	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,073,550	234,248	2,963,401	2,500,757	26,029	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.552278	0.039467	29,634.010000	24,759.970297	257.712871	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	151,792	115,752	149,338	102,008	3,787	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.260041	0.014420	1,493.380000	1,009.980198	37.495050	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			NURSING ADMINISTRATION (HOURS SUPERVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	13.00	14.00	15.00	16.00	17.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
		19.00	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
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
76.00	03160	STRESS TESTING	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.01
76.02	03610	SLEEP LAB	0	76.02
76.97	07697	CARDIAC REHABILITATION	0	76.97
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	0	116.00
117.00	06950	HOMEMAKER	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	CARDINAL SLEEP	0	194.00
194.01	07951	OTHER NRCC	0	194.01
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,642	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.420000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	48	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.480000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet B-1

Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description		NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)	
		19.00	23.00	
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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

			Title XVIII		Hospital		PPS	
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	13,494,490		13,494,490	2,647	13,497,137	30.00
31.00	03100	INTENSIVE CARE UNIT	2,087,449		2,087,449	0	2,087,449	31.00
40.00	04000	SUBPROVIDER - IPF	1,264,950		1,264,950	0	1,264,950	40.00
43.00	04300	NURSERY	443,717		443,717	0	443,717	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,038,272		5,038,272	0	5,038,272	50.00
51.00	05100	RECOVERY ROOM	1,437,176		1,437,176	0	1,437,176	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,350,841		2,350,841	0	2,350,841	52.00
53.00	05300	ANESTHESIOLOGY	2,013,388		2,013,388	170,950	2,184,338	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,870,964		12,870,964	0	12,870,964	54.00
58.00	05800	MRI	713,451		713,451	0	713,451	58.00
60.00	06000	LABORATORY	7,569,365		7,569,365	0	7,569,365	60.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,946,414	0	1,946,414	0	1,946,414	65.00
66.00	06600	PHYSICAL THERAPY	4,877,374	0	4,877,374	32,870	4,910,244	66.00
67.00	06700	OCCUPATIONAL THERAPY	712,666	0	712,666	0	712,666	67.00
68.00	06800	SPEECH PATHOLOGY	297,212	0	297,212	0	297,212	68.00
69.00	06900	ELECTROCARDIOLOGY	315,408		315,408	0	315,408	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,331		7,331	0	7,331	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,234,160		3,234,160	0	3,234,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,915,766		1,915,766	0	1,915,766	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,538,696		8,538,696	0	8,538,696	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,743,635		3,743,635	0	3,743,635	75.00
76.00	03160	STRESS TESTING	0		0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,608,572		2,608,572	22,654	2,631,226	76.01
76.02	03610	SLEEP LAB	324,347		324,347	0	324,347	76.02
76.97	07697	CARDIAC REHABILITATION	1,067,731		1,067,731	0	1,067,731	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,014,750		9,014,750	252,175	9,266,925	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,975,029		1,975,029		1,975,029	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		0		0	116.00
117.00	06950	HOMEMAKER	0		0		0	117.00
200.00		Subtotal (see instructions)	89,863,154	0	89,863,154	481,296	90,344,450	200.00
201.00		Less Observation Beds	1,975,029		1,975,029		1,975,029	201.00
202.00		Total (see instructions)	87,888,125	0	87,888,125	481,296	88,369,421	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

			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	18,124,669		18,124,669		30.00
31.00	03100	INTENSIVE CARE UNIT	3,028,862		3,028,862		31.00
40.00	04000	SUBPROVIDER - IPF	3,552,426		3,552,426		40.00
43.00	04300	NURSERY	866,109		866,109		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,266,473	22,602,724	28,869,197	0.174521	50.00
51.00	05100	RECOVERY ROOM	514,958	4,009,219	4,524,177	0.317666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,444,355	2,884,236	7,328,591	0.320777	52.00
53.00	05300	ANESTHESIOLOGY	2,909,276	8,113,523	11,022,799	0.182657	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,634,991	88,393,503	98,028,494	0.131298	54.00
58.00	05800	MRI	762,610	12,959,092	13,721,702	0.051994	58.00
60.00	06000	LABORATORY	14,314,970	51,125,967	65,440,937	0.115667	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,903,075	3,618,627	7,521,702	0.258773	65.00
66.00	06600	PHYSICAL THERAPY	786,024	15,294,704	16,080,728	0.303306	66.00
67.00	06700	OCCUPATIONAL THERAPY	179,705	1,833,657	2,013,362	0.353968	67.00
68.00	06800	SPEECH PATHOLOGY	92,143	468,392	560,535	0.530229	68.00
69.00	06900	ELECTROCARDIOLOGY	961,009	2,602,170	3,563,179	0.088519	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	15,432	72,095	87,527	0.083757	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,597,523	10,411,111	18,008,634	0.179589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,066,302	5,086,342	8,152,644	0.234987	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,009,706	18,124,912	29,134,618	0.293077	73.00
75.00	07500	ASC (NON-DISTINCT PART)	719,105	14,229,682	14,948,787	0.250431	75.00
76.00	03160	STRESS TESTING	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,893	4,096,560	4,103,453	0.635702	76.01
76.02	03610	SLEEP LAB	0	1,082,520	1,082,520	0.299622	76.02
76.97	07697	CARDIAC REHABILITATION	1,798,901	8,284,456	10,083,357	0.105890	76.97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,201,096	29,529,939	35,731,035	0.252295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,953,796	3,325,650	5,279,446	0.374098	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
117.00	06950	HOMEMAKER	0	0	0		117.00
200.00		Subtotal (see instructions)	102,710,409	308,149,081	410,859,490		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	102,710,409	308,149,081	410,859,490		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.174521			50.00
51.00	05100	RECOVERY ROOM	0.317666			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.320777			52.00
53.00	05300	ANESTHESIOLOGY	0.198165			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131298			54.00
58.00	05800	MRI	0.051994			58.00
60.00	06000	LABORATORY	0.115667			60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.258773			65.00
66.00	06600	PHYSICAL THERAPY	0.305350			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353968			67.00
68.00	06800	SPEECH PATHOLOGY	0.530229			68.00
69.00	06900	ELECTROCARDIOLOGY	0.088519			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.083757			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179589			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234987			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293077			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.250431			75.00
76.00	03160	STRESS TESTING	0.000000			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.641222			76.01
76.02	03610	SLEEP LAB	0.299622			76.02
76.97	07697	CARDIAC REHABILITATION	0.105890			76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.259352			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.374098			92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
117.00	06950	HOMEMAKER				117.00
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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	13,494,490		13,494,490	2,647	13,497,137	30.00	
31.00	03100	INTENSIVE CARE UNIT	2,087,449		2,087,449	0	2,087,449	31.00	
40.00	04000	SUBPROVIDER - IPF	1,264,950		1,264,950	0	1,264,950	40.00	
43.00	04300	NURSERY	443,717		443,717	0	443,717	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	5,038,272		5,038,272	0	5,038,272	50.00	
51.00	05100	RECOVERY ROOM	1,437,176		1,437,176	0	1,437,176	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,350,841		2,350,841	0	2,350,841	52.00	
53.00	05300	ANESTHESIOLOGY	2,013,388		2,013,388	170,950	2,184,338	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,870,964		12,870,964	0	12,870,964	54.00	
58.00	05800	MRI	713,451		713,451	0	713,451	58.00	
60.00	06000	LABORATORY	7,569,365		7,569,365	0	7,569,365	60.00	
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	1,946,414	0	1,946,414	0	1,946,414	65.00	
66.00	06600	PHYSICAL THERAPY	4,877,374	0	4,877,374	32,870	4,910,244	66.00	
67.00	06700	OCCUPATIONAL THERAPY	712,666	0	712,666	0	712,666	67.00	
68.00	06800	SPEECH PATHOLOGY	297,212	0	297,212	0	297,212	68.00	
69.00	06900	ELECTROCARDIOLOGY	315,408		315,408	0	315,408	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	7,331		7,331	0	7,331	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,234,160		3,234,160	0	3,234,160	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,915,766		1,915,766	0	1,915,766	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	8,538,696		8,538,696	0	8,538,696	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	3,743,635		3,743,635	0	3,743,635	75.00	
76.00	03160	STRESS TESTING	0		0	0	0	76.00	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,608,572		2,608,572	22,654	2,631,226	76.01	
76.02	03610	SLEEP LAB	324,347		324,347	0	324,347	76.02	
76.97	07697	CARDIAC REHABILITATION	1,067,731		1,067,731	0	1,067,731	76.97	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	9,014,750		9,014,750	252,175	9,266,925	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,975,029		1,975,029		1,975,029	92.00	
OTHER REIMBURSABLE COST CENTERS									
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0		0		0	116.00	
117.00	06950	HOMEMAKER	0		0		0	117.00	
200.00		Subtotal (see instructions)	89,863,154	0	89,863,154	481,296	90,344,450	200.00	
201.00		Less Observation Beds	1,975,029		1,975,029		1,975,029	201.00	
202.00		Total (see instructions)	87,888,125	0	87,888,125	481,296	88,369,421	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

			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
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,124,669		18,124,669			30.00	
31.00	03100	INTENSIVE CARE UNIT	3,028,862		3,028,862			31.00	
40.00	04000	SUBPROVIDER - IPF	3,552,426		3,552,426			40.00	
43.00	04300	NURSERY	866,109		866,109			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,266,473	22,602,724	28,869,197	0.174521	0.000000	50.00	
51.00	05100	RECOVERY ROOM	514,958	4,009,219	4,524,177	0.317666	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,444,355	2,884,236	7,328,591	0.320777	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	2,909,276	8,113,523	11,022,799	0.182657	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,634,991	88,393,503	98,028,494	0.131298	0.000000	54.00	
58.00	05800	MRI	762,610	12,959,092	13,721,702	0.051994	0.000000	58.00	
60.00	06000	LABORATORY	14,314,970	51,125,967	65,440,937	0.115667	0.000000	60.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	3,903,075	3,618,627	7,521,702	0.258773	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	786,024	15,294,704	16,080,728	0.303306	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	179,705	1,833,657	2,013,362	0.353968	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	92,143	468,392	560,535	0.530229	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	961,009	2,602,170	3,563,179	0.088519	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	15,432	72,095	87,527	0.083757	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,597,523	10,411,111	18,008,634	0.179589	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,066,302	5,086,342	8,152,644	0.234987	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	11,009,706	18,124,912	29,134,618	0.293077	0.000000	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	719,105	14,229,682	14,948,787	0.250431	0.000000	75.00	
76.00	03160	STRESS TESTING	0	0	0	0.000000	0.000000	76.00	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,893	4,096,560	4,103,453	0.635702	0.000000	76.01	
76.02	03610	SLEEP LAB	0	1,082,520	1,082,520	0.299622	0.000000	76.02	
76.97	07697	CARDIAC REHABILITATION	1,798,901	8,284,456	10,083,357	0.105890	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	6,201,096	29,529,939	35,731,035	0.252295	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,953,796	3,325,650	5,279,446	0.374098	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
116.00	11600	HOSPICE	0	0	0			116.00	
117.00	06950	HOMEMAKER	0	0	0			117.00	
200.00		Subtotal (see instructions)	102,710,409	308,149,081	410,859,490			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	102,710,409	308,149,081	410,859,490			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet C
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

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
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
58.00	05800	MRI	0.000000			58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000			75.00
76.00	03160	STRESS TESTING	0.000000			76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000			76.01
76.02	03610	SLEEP LAB	0.000000			76.02
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
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
117.00	06950	HOMEMAKER				117.00
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: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	776,129	0	776,129	13,866	55.97	30.00
31.00	INTENSIVE CARE UNIT	115,875		115,875	998	116.11	31.00
40.00	SUBPROVIDER - IPF	77,326	0	77,326	1,753	44.11	40.00
43.00	NURSERY	14,007		14,007	895	15.65	43.00
200.00	Total (lines 30 through 199)	983,337		983,337	17,512		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	4,899	274,197				
31.00	INTENSIVE CARE UNIT	573	66,531				
40.00	SUBPROVIDER - IPF	866	38,199				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	6,338	378,927				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description			Title XVIII		Hospital	PPS	
			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	758,844	28,869,197	0.026286	3,225,375	84,782
51.00	05100	RECOVERY ROOM	50,407	4,524,177	0.011142	264,455	2,947
52.00	05200	DELIVERY ROOM & LABOR ROOM	74,903	7,328,591	0.010221	343,884	3,515
53.00	05300	ANESTHESIOLOGY	131,370	11,022,799	0.011918	1,418,074	16,901
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,079,250	98,028,494	0.011010	5,600,603	61,663
58.00	05800	MRI	31,668	13,721,702	0.002308	458,542	1,058
60.00	06000	LABORATORY	461,346	65,440,937	0.007050	7,121,011	50,203
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0
65.00	06500	RESPIRATORY THERAPY	93,891	7,521,702	0.012483	2,473,540	30,877
66.00	06600	PHYSICAL THERAPY	320,398	16,080,728	0.019924	530,872	10,577
67.00	06700	OCCUPATIONAL THERAPY	32,378	2,013,362	0.016082	114,508	1,842
68.00	06800	SPEECH PATHOLOGY	11,120	560,535	0.019838	63,221	1,254
69.00	06900	ELECTROCARDIOLOGY	9,786	3,563,179	0.002746	571,209	1,569
70.00	07000	ELECTROENCEPHALOGRAPHY	221	87,527	0.002525	8,964	23
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,481	18,008,634	0.006912	4,434,741	30,653
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,067	8,152,644	0.008840	1,832,220	16,197
73.00	07300	DRUGS CHARGED TO PATIENTS	312,100	29,134,618	0.010712	4,929,930	52,809
75.00	07500	ASC (NON-DISTINCT PART)	450,315	14,948,787	0.030124	349,997	10,543
76.00	03160	STRESS TESTING	0	0	0.000000	0	0
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	100,740	4,103,453	0.024550	780	19
76.02	03610	SLEEP LAB	53,266	1,082,520	0.049206	0	0
76.97	07697	CARDIAC REHABILITATION	31,556	10,083,357	0.003130	1,146,840	3,590
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	399,947	35,731,035	0.011193	3,138,277	35,127
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	113,570	5,279,446	0.021512	1,290,291	27,757
200.00		Total (lines 50 through 199)	4,713,624	385,287,424		39,317,334	443,906

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 14-0110		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part III Date/Time Prepared: 2/27/2019 2:29 pm	
						Title XVIII		Hospital		PPS	
Cost Center Description						Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
						1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF		0	0	0	0	0	0	0	40.00
43.00	04300	NURSERY		0	0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	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	13,866	0.00	4,899	30.00		
31.00	03100	INTENSIVE CARE UNIT			0	998	0.00	573	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	1,753	0.00	866	40.00		
43.00	04300	NURSERY			0	895	0.00	0	43.00		
200.00		Total (lines 30 through 199)			0	17,512		6,338	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		
40.00	04000	SUBPROVIDER - IPF		0					40.00		
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: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 2:29 pm

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	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
58.00	05800	MRI	0	0	0	0	58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
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	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03160	STRESS TESTING	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	76.01
76.02	03610	SLEEP LAB	0	0	0	0	76.02
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	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 2:29 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	28,869,197	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,524,177	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,328,591	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,022,799	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	98,028,494	0.000000	54.00
58.00	05800	MRI	0	0	0	13,721,702	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	65,440,937	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,521,702	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,080,728	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,013,362	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	560,535	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,563,179	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	87,527	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,008,634	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,152,644	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	29,134,618	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	14,948,787	0.000000	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,103,453	0.000000	76.01
76.02	03610	SLEEP LAB	0	0	0	1,082,520	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	10,083,357	0.000000	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	0	0	35,731,035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,279,446	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	385,287,424		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part IV
Date/Time Prepared:
2/27/2019 2:29 pm

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	3,225,375	0	7,991,179	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	264,455	0	1,340,865	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	343,884	0	10,798	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,418,074	0	2,642,048	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	5,600,603	0	28,014,971	0	54.00
58.00	05800	MRI	0.000000	458,542	0	2,462,945	0	58.00
60.00	06000	LABORATORY	0.000000	7,121,011	0	6,540,505	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	2,473,540	0	1,143,436	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	530,872	0	1,035,439	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	114,508	0	6,853	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	63,221	0	1,945	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	571,209	0	887,564	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	8,964	0	18,949	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,434,741	0	4,119,322	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,832,220	0	2,018,824	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	4,929,930	0	7,028,132	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	349,997	0	5,206,191	0	75.00
76.00	03160	STRESS TESTING	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	780	0	987,418	0	76.01
76.02	03610	SLEEP LAB	0.000000	0	0	487,697	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	1,146,840	0	2,622,775	0	76.97
	OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0.000000	3,138,277	0	7,633,108	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,290,291	0	986,450	0	92.00
200.00		Total (lines 50 through 199)		39,317,334	0	83,187,414	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part V
Date/Time Prepared:
2/27/2019 2:29 pm

			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	0.174521	7,991,179	0	0	1,394,629	50.00	
51.00	05100	RECOVERY ROOM	0.317666	1,340,865	0	0	425,947	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.320777	10,798	0	0	3,464	52.00	
53.00	05300	ANESTHESIOLOGY	0.182657	2,642,048	0	0	482,589	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131298	28,014,971	0	0	3,678,310	54.00	
58.00	05800	MRI	0.051994	2,462,945	0	0	128,058	58.00	
60.00	06000	LABORATORY	0.115667	6,540,505	5,382	0	756,521	60.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.258773	1,143,436	0	0	295,890	65.00	
66.00	06600	PHYSICAL THERAPY	0.303306	1,035,439	0	0	314,055	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.353968	6,853	0	0	2,426	67.00	
68.00	06800	SPEECH PATHOLOGY	0.530229	1,945	0	0	1,031	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.088519	887,564	0	0	78,566	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.083757	18,949	0	0	1,587	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179589	4,119,322	0	0	739,785	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234987	2,018,824	0	0	474,397	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293077	7,028,132	0	90,057	2,059,784	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0.250431	5,206,191	0	0	1,303,792	75.00	
76.00	03160	STRESS TESTING	0.000000	0	0	0	0	76.00	
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.635702	987,418	0	0	627,704	76.01	
76.02	03610	SLEEP LAB	0.299622	487,697	0	0	146,125	76.02	
76.97	07697	CARDIAC REHABILITATION	0.105890	2,622,775	0	0	277,726	76.97	
	OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.252295	7,633,108	0	0	1,925,795	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.374098	986,450	0	0	369,029	92.00	
200.00		Subtotal (see instructions)		83,187,414	5,382	90,057	15,487,210	200.00	
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00	
		Only Charges							
202.00		Net Charges (line 200 - line 201)		83,187,414	5,382	90,057	15,487,210	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet D
Part V
Date/Time Prepared:
2/27/2019 2:29 pm

			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	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	623	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
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	26,394		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03160	STRESS TESTING	0	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.01
76.02	03610	SLEEP LAB	0	0		76.02
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)	623	26,394		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	623	26,394		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0110

Period:

Worksheet D

Component CCN: 14-S110

From 10/01/2017
To 09/30/2018Part II
Date/Time Prepared:
2/27/2019 2:29 pm

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	758,844	28,869,197	0.026286	0	50.00
51.00	05100	RECOVERY ROOM	50,407	4,524,177	0.011142	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	74,903	7,328,591	0.010221	316	52.00
53.00	05300	ANESTHESIOLOGY	131,370	11,022,799	0.011918	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,079,250	98,028,494	0.011010	71,753	54.00
58.00	05800	MRI	31,668	13,721,702	0.002308	5,504	58.00
60.00	06000	LABORATORY	461,346	65,440,937	0.007050	325,500	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	93,891	7,521,702	0.012483	40,469	65.00
66.00	06600	PHYSICAL THERAPY	320,398	16,080,728	0.019924	5,141	66.00
67.00	06700	OCCUPATIONAL THERAPY	32,378	2,013,362	0.016082	520	67.00
68.00	06800	SPEECH PATHOLOGY	11,120	560,535	0.019838	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,786	3,563,179	0.002746	14,860	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	221	87,527	0.002525	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	124,481	18,008,634	0.006912	11,282	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72,067	8,152,644	0.008840	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	312,100	29,134,618	0.010712	256,878	73.00
75.00	07500	ASC (NON-DISTINCT PART)	450,315	14,948,787	0.030124	50	75.00
76.00	03160	STRESS TESTING	0	0	0.000000	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	100,740	4,103,453	0.024550	4,093	76.01
76.02	03610	SLEEP LAB	53,266	1,082,520	0.049206	0	76.02
76.97	07697	CARDIAC REHABILITATION	31,556	10,083,357	0.003130	6,494	76.97
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	399,947	35,731,035	0.011193	181,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,279,446	0.000000	5,744	92.00
200.00		Total (lines 50 through 199)	4,600,054	385,287,424		930,192	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0110 Component CCN: 14-S110		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/27/2019 2:29 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
58.00	05800	MRI		0	0	0	0	0	58.00
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
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03160	STRESS TESTING		0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0	0	0	0	0	76.01
76.02	03610	SLEEP LAB		0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0110 Component CCN: 14-S110		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/27/2019 2:29 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	28,869,197	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,524,177	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,328,591	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,022,799	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	98,028,494	0.000000	54.00
58.00	05800	MRI	0	0	0	13,721,702	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	65,440,937	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	7,521,702	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,080,728	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,013,362	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	560,535	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,563,179	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	87,527	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,008,634	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,152,644	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	29,134,618	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	14,948,787	0.000000	75.00
76.00	03160	STRESS TESTING	0	0	0	0	0.000000	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,103,453	0.000000	76.01
76.02	03610	SLEEP LAB	0	0	0	1,082,520	0.000000	76.02
76.97	07697	CARDIAC REHABILITATION	0	0	0	10,083,357	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	35,731,035	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,279,446	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	385,287,424		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0110 Component CCN: 14-S110		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/27/2019 2:29 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	316	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	71,753	0	0	0	0	54.00
58.00	05800	MRI	0.000000	5,504	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	325,500	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	40,469	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	5,141	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	520	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,860	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	11,282	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	256,878	0	0	67	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	50	0	0	0	0	75.00
76.00	03160	STRESS TESTING	0.000000	0	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	4,093	0	0	1,018	0	76.01
76.02	03610	SLEEP LAB	0.000000	0	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.000000	6,494	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000	181,588	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	5,744	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		930,192	0	0	1,085	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0110

Period:

Worksheet D

Component CCN: 14-S110

From 10/01/2017
To 09/30/2018Part V
Date/Time Prepared:
2/27/2019 2:29 pm

Title XVIII

Subprovider -
IPF

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	0.174521	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.317666	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.320777	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.182657	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131298	0	0	0	0	54.00
58.00	05800	MRI	0.051994	0	0	0	0	58.00
60.00	06000	LABORATORY	0.115667	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.258773	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.303306	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353968	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.530229	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088519	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.083757	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179589	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234987	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293077	67	0	83	20	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.250431	0	0	0	0	75.00
76.00	03160	STRESS TESTING	0.000000	0	0	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.635702	1,018	0	0	647	76.01
76.02	03610	SLEEP LAB	0.299622	0	0	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.105890	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.252295	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.374098	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,085	0	83	667	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,085	0	83	667	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0110

Period:

Worksheet D

Component CCN: 14-S110

From 10/01/2017
To 09/30/2018Part V
Date/Time Prepared:
2/27/2019 2:29 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost	Cost		
			Reimbursed	Reimbursed		
			Services Subject To Ded. & Coins. (see inst.)	Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
58.00	05800	MRI	0	0		58.00
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
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	24		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03160	STRESS TESTING	0	0		76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.01
76.02	03610	SLEEP LAB	0	0		76.02
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	24		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	24		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 2:29 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			13,866	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			13,866	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)			11,837	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			4,899	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)			13,497,137	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)			13,497,137	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)			13,497,137	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)			973.40	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			4,768,687	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)			4,768,687	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/27/2019 2:29 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	2,087,449	998	2,091.63	573	1,198,504
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
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)					7,726,667
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					13,693,858
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					340,728
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					443,906
52.00	Total Program excludable cost (sum of lines 50 and 51)					784,634
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					12,909,224
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)					2,029
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					973.40
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,975,029

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet D-1

Date/Time Prepared:
2/27/2019 2:29 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	776,129	13,497,137	0.057503	1,975,029	113,570	90.00
91.00 Nursing School cost	0	13,497,137	0.000000	1,975,029	0	91.00
92.00 Allied health cost	0	13,497,137	0.000000	1,975,029	0	92.00
93.00 All other Medical Education	0	13,497,137	0.000000	1,975,029	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 2:29 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,753	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,753	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,753	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)		866	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)		1,264,950	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)		1,264,950	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)		1,264,950	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)		721.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		624,897	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)		624,897	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0110

Period:

Worksheet D-1

Component CCN: 14-S110

From 10/01/2017

Date/Time Prepared:

To 09/30/2018

2/27/2019 2:29 pm

Title XVIII

Subprovider -

PPS

Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					190,880	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					815,777	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)					38,199	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,742	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					46,941	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					768,836	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: 14-0110 Component CCN: 14-S110		Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 2:29 pm	
			Title XVIII		Subprovider - IPF	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	77,326	1,264,950	0.061130	0	0	90.00
91.00	Nursing School cost	0	1,264,950	0.000000	0	0	91.00
92.00	Allied health cost	0	1,264,950	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,264,950	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 2:29 pm	
Cost Center Description			Title XVIII	Hospital	PPS	
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		6,558,071		30.00
31.00	03100	INTENSIVE CARE UNIT		1,646,942		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.174521	3,225,375	562,896	50.00
51.00	05100	RECOVERY ROOM	0.317666	264,455	84,008	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.320777	343,884	110,310	52.00
53.00	05300	ANESTHESIOLOGY	0.198165	1,418,074	281,013	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.131298	5,600,603	735,348	54.00
58.00	05800	MRI	0.051994	458,542	23,841	58.00
60.00	06000	LABORATORY	0.115667	7,121,011	823,666	60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.258773	2,473,540	640,085	65.00
66.00	06600	PHYSICAL THERAPY	0.305350	530,872	162,102	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.353968	114,508	40,532	67.00
68.00	06800	SPEECH PATHOLOGY	0.530229	63,221	33,522	68.00
69.00	06900	ELECTROCARDIOLOGY	0.088519	571,209	50,563	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.083757	8,964	751	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.179589	4,434,741	796,431	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.234987	1,832,220	430,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.293077	4,929,930	1,444,849	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.250431	349,997	87,650	75.00
76.00	03160	STRESS TESTING	0.000000	0	0	76.00
76.01	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.641222	780	500	76.01
76.02	03610	SLEEP LAB	0.299622	0	0	76.02
76.97	07697	CARDIAC REHABILITATION	0.105890	1,146,840	121,439	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	0.259352	3,138,277	813,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.374098	1,290,291	482,695	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		39,317,334	7,726,667	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)		39,317,334		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 2:29 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		1,704,345		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.174521	0	0	50.00
51.00	05100 RECOVERY ROOM	0.317666	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.320777	316	101	52.00
53.00	05300 ANESTHESIOLOGY	0.198165	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.131298	71,753	9,421	54.00
58.00	05800 MRI	0.051994	5,504	286	58.00
60.00	06000 LABORATORY	0.115667	325,500	37,650	60.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.258773	40,469	10,472	65.00
66.00	06600 PHYSICAL THERAPY	0.305350	5,141	1,570	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.353968	520	184	67.00
68.00	06800 SPEECH PATHOLOGY	0.530229	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.088519	14,860	1,315	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.083757	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.179589	11,282	2,026	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.234987	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.293077	256,878	75,285	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.250431	50	13	75.00
76.00	03160 STRESS TESTING	0.000000	0	0	76.00
76.01	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.641222	4,093	2,625	76.01
76.02	03610 SLEEP LAB	0.299622	0	0	76.02
76.97	07697 CARDIAC REHABILITATION	0.105890	6,494	688	76.97
OUTPATIENT SERVICE COST CENTERS					
91.00	09100 EMERGENCY	0.259352	181,588	47,095	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.374098	5,744	2,149	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		930,192	190,880	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)		930,192		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet E
Part A
Date/Time Prepared:
2/27/2019 2:29 pm

		Title XVIII	Hospital	PPS	
			Before GEO Reclass	On/After GEO Reclass	
			1.00	1.01	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,713,499	0	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	0	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	0	0	1.04
2.00	Outlier payments for discharges. (see instructions)	19,506	0	0	2.00
2.01	Outlier reconciliation amount	0	0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	0	0	2.02
3.00	Managed Care Simulated Payments	0	0	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	84.44			4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.68		30.00
31.00	Percentage of Medicaid patient days (see instructions)		34.64		31.00
32.00	Sum of lines 30 and 31		39.32		32.00
33.00	Allowable disproportionate share percentage (see instructions)		21.65	21.65	33.00
34.00	Disproportionate share adjustment (see instructions)		579,868	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 2:29 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	445,958	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	445,958	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		445,958		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before GEO Reclass	On/After GEO Reclass	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 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	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)		11,312,873	445,958	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	0	48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			11,758,831	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			875,375	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see 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)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			12,634,206	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			12,634,206	61.00
62.00	Deductibles billed to program beneficiaries			1,517,624	62.00
63.00	Coinurance billed to program beneficiaries			9,374	63.00
64.00	Allowable bad debts (see instructions)			492,525	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			320,141	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			435,480	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			11,427,349	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)			15,952	70.93
70.94	HRR adjustment amount (see instructions)			-56,782	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet E
Part A
Date/Time Prepared:
2/27/2019 2:29 pm

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		125,934	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		11,260,585	71.00	
71.01	Sequestration adjustment (see instructions)		225,212	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		11,075,628	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)		-40,255	74.00	
75.00	Contested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		304,924	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVB Adjustment for HSP Bonus Payment					
101.00	HVB adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVB adjustment amount for HSP bonus payment (see instructions)		0	102.00	
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2019 2:29 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,713,499		10,713,499	10,713,499	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	19,506	0	19,506	19,506	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	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	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	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2165	0.2165	0.2165		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	579,868	0	579,868	579,868	11.00
11.01	Uncompensated care payments	36.00	445,958	0	445,958	445,958	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	11,758,831	0	11,758,831	11,758,831	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	11,758,831	0	11,758,831	11,758,831	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	875,375	0	875,375	875,375	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			0	12,634,206	12,634,206	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/27/2019 2:29 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	872,716	0	872,716	872,716	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	2,659	0	2,659	2,659	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	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	875,375	0	875,375	875,375	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	15,952	0	15,952	15,952	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	-56,782	0	-56,782	-56,782	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	125,934	125,934	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 2:29 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		27,017	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		15,487,210	2.00
3.00	OPPS payments		12,184,615	3.00
4.00	Outlier payment (see instructions)		51,547	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		27,017	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		95,439	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)		95,439	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)		95,439	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		68,422	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)		27,017	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)		12,236,162	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,463,523	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		9,799,656	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		9,799,656	30.00
31.00	Primary payer payments		724	31.00
32.00	Subtotal (line 30 minus line 31)		9,798,932	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)		712,881	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		463,373	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		618,286	36.00
37.00	Subtotal (see instructions)		10,262,305	37.00
38.00	MSP-LCC reconciliation amount from PS&R		46	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,262,259	40.00
40.01	Sequestration adjustment (see instructions)		205,245	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		9,773,337	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		283,677	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: 14-0110 Component CCN: 14-S110	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 2:29 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)		24	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		667	2.00
3.00	OPPS payments		324	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		24	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		83	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)		83	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)		83	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		59	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		24	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)		324	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		58	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)		290	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)		290	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		290	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)		290	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)		290	40.00
40.01	Sequestration adjustment (see instructions)		6	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		277	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		7	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)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part I
Date/Time Prepared:
2/27/2019 2:29 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		11,075,628		9,773,337	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		11,075,628		9,773,337	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		283,677	6.01
6.02	SETTLEMENT TO PROGRAM		40,255		0	6.02
7.00	Total Medicare program liability (see instructions)		11,035,373		10,057,014	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: 14-0110
 Component CCN: 14-S110

 Period:
 From 10/01/2017
 To 09/30/2018

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/27/2019 2:29 pm

		Title XVIII		Subprovider - IPF		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		658,945		277	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		658,945		277	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		7	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		658,945		284	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet E-1
Part II
Date/Time Prepared:
2/27/2019 2:29 pm

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0110 Component CCN: 14-S110	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part II Date/Time Prepared: 2/27/2019 2:29 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	809,813	1.00	
2.00	Net IPF PPS Outlier Payments	0	2.00	
3.00	Net IPF PPS ECT Payments	0	3.00	
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00	
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01	
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00	
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	6.00	
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	7.00	
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00	
9.00	Average Daily Census (see instructions)	4.802740	9.00	
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.	0.000000	10.00	
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00	
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	809,813	12.00	
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00	
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00	
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00	
16.00	Subtotal (see instructions)	809,813	16.00	
17.00	Primary payer payments	0	17.00	
18.00	Subtotal (line 16 less line 17).	809,813	18.00	
19.00	Deductibles	126,700	19.00	
20.00	Subtotal (line 18 minus line 19)	683,113	20.00	
21.00	Coinurance	10,720	21.00	
22.00	Subtotal (line 20 minus line 21)	672,393	22.00	
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	23.00	
24.00	Adjusted reimbursable bad debts (see instructions)	0	24.00	
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00	
26.00	Subtotal (sum of lines 22 and 24)	672,393	26.00	
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00	
28.00	Other pass through costs (see instructions)	0	28.00	
29.00	Outlier payments reconciliation	0	29.00	
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00	
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50	
30.99	Demonstration payment adjustment amount before sequestration	0	30.99	
31.00	Total amount payable to the provider (see instructions)	672,393	31.00	
31.01	Sequestration adjustment (see instructions)	13,448	31.01	
31.02	Demonstration payment adjustment amount after sequestration	0	31.02	
32.00	Interim payments	658,945	32.00	
33.00	Tentative settlement (for contractor use only)	0	33.00	
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	0	34.00	
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00	
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00	
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00	
52.00	The rate used to calculate the Time Value of Money	0.00	52.00	
53.00	Time Value of Money (see instructions)	0	53.00	

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

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet G

Date/Time Prepared:
2/27/2019 2:29 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,299,509	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	72,965,033	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-53,288,902	0	0	0	6.00
7.00	Inventory	2,849,975	0	0	0	7.00
8.00	Prepaid expenses	21,021	0	0	0	8.00
9.00	Other current assets	724,093	0	0	0	9.00
10.00	Due from other funds	100,929	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,671,658	0	0	0	11.00
FIXED ASSETS						
12.00	Land	3,227,906	0	0	0	12.00
13.00	Land improvements	2,818,034	0	0	0	13.00
14.00	Accumulated depreciation	-2,420,975	0	0	0	14.00
15.00	Buildings	67,020,213	0	0	0	15.00
16.00	Accumulated depreciation	-39,131,087	0	0	0	16.00
17.00	Leasehold improvements	0	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	37,934,883	0	0	0	23.00
24.00	Accumulated depreciation	-25,736,344	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	266,342	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	43,978,972	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,733,991	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	2,032,801	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,766,792	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	72,417,422	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,622,617	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,324,488	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	703,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	6,721,020	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	15,371,125	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	28,188,544	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	28,188,544	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	43,559,669	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	28,857,753				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)	28,857,753	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	72,417,422	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-1

Date/Time Prepared:
2/27/2019 2:29 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		35,417,945		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-8,434,566				2.00
3.00	Total (sum of line 1 and line 2)		26,983,379		0		3.00
4.00	CONTRIBUTIONS	1,874,374		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,874,374		0		10.00
11.00	Subtotal (line 3 plus line 10)		28,857,753		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28,857,753		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	CONTRIBUTIONS		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
2/27/2019 2:29 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	18,990,778		18,990,778	1.00
2.00	SUBPROVIDER - IPF	3,552,426		3,552,426	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	22,543,204		22,543,204	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,028,862		3,028,862	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,028,862		3,028,862	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	25,572,066		25,572,066	17.00
18.00	Ancillary services	68,183,989	276,093,574	344,277,563	18.00
19.00	Outpatient services	8,154,892	32,855,589	41,010,481	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		0	0	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	0	0	0	26.00
27.00	PRO FEES	5,473,022	26,478,343	31,951,365	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	107,383,969	335,427,506	442,811,475	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		104,746,834		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		104,746,834		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0110

Period:
From 10/01/2017
To 09/30/2018

Worksheet G-3

Date/Time Prepared:
2/27/2019 2:29 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	442,811,475	1.00
2.00	Less contractual allowances and discounts on patients' accounts	333,763,444	2.00
3.00	Net patient revenues (line 1 minus line 2)	109,048,031	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	104,746,834	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,301,197	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	26,599	6.00
7.00	Income from investments	7,586	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	341,580	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	993	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	25,813	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	348,862	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,127,126	24.00
24.01	COMMUNITY HEALTH ED	15,461	24.01
24.02	GAIN ON DISPOSAL OF ASSETS	5,723	24.02
24.03	RISK & VALUE BASED REVENUE	278,879	24.03
25.00	Total other income (sum of lines 6-24)	2,178,622	25.00
26.00	Total (line 5 plus line 25)	6,479,819	26.00
27.00	EQUITY XFER	14,914,385	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	14,914,385	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-8,434,566	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0110	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/27/2019 2:29 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		872,716	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,659	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)		35.67	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		875,375	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