

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report	Date: _____	Time: _____
		2. ☐ Manually submitted cost report		
		3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report		
		4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. ☐ Cost Report Status	6. Date Received: _____	10. NPR Date: _____	
	(1) As Submitted	7. Contractor No.: _____	11. Contractor's Vendor Code: ____	
	(2) Settled without audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4:	
	(3) Settled with audit	9. ☐ Final Report for this Provider CCN	Enter number of times reopened = 0-9.	
	(4) Reopened			
	(5) Amended			

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 JACKSON PARK HOSPITAL (14-0177) {(Provider Name(s) and Number(s))} for the cost reporting period beginning 04/01/2017 and ending 03/31/2018, 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) _____
Chief Financial Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		963,953	-55,158			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		963,953	-55,158			200

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 this 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 this 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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 7531 SOUTH STONEY ISLAND AVENUE	P.O. Box:		1
2	City: CHICAGO	State: IL	ZIP Code: 60649	County: COOK

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	JACKSON PARK HOSPITAL	14-0177	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	JACKSON PARK HOSPITAL	14-S177	16974	4	07 / 01 / 1966	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2017	To: 03 / 31 / 2018		20
21	Type of control (see instructions)	2			21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments 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 §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
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	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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	1,659	1,155		2	13,299	43	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, 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.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	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.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	45
46	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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
	Teaching Hospitals				
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
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 baseline 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

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.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

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 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

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.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	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)						66
Enter in lines 67-67.49, column 1 the program name. 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)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed 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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is yes: Column 1: Did the facility have a 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 and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	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

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	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
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	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
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	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.	N	Y	98.06

Rural Providers

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)					106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions)					107
	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.					
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
109	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 each therapy.	Physical	Occupational	Speech	Respiratory	109
1						
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N		110
				1	2	
111	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.					111

Miscellaneous Cost Reporting Information

115	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-L, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	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.				118
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N		120
121	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
122	Does the cost report contain state health care related taxes as defined in §1983(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

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

All Providers

		1	2	
140	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)	N		140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	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
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	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)				168
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	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
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		04 / 01 / 2017	03 / 31 / 2018	170
171	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 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

		Y/N	Date		
Provider Organization and Operation		1	2		
1	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
		Y/N	Date	V/I	
		1	2	3	
2	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
3	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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	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.	N			4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	Y			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts		Y	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

		Y/N	
Bed Complement		N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/25/2018	Y	07/25/2018	17
18	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 the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	28
29	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
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	34
35	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

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information				
41	First name: RAJ	Last name: SHAH	Title: MANAGER	41
42	Employer: STRATEGIC REIMBURSEMENT GROUP, LLC			42
43	Phone number: 630-530-7100 X 107	E-mail Address: RAJ.SHAH@SRGROUPLLC.COM		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	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	107	39,055			3,732	976	18,227	1
2	HMO and other (see instructions)						847	14,499		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		107	39,055			3,732	976	18,227	7
8	Intensive Care Unit	31	8	2,920			572	151	2,059	8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						69	71	13
14	Total (see instructions)		115	41,975			4,304	1,196	20,357	14
15	CAH Visits									15
16	Subprovider - IPF	40	86	31,390			1,714	448	8,373	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30							101	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		201							27
28	Observation Bed Days							145	2,067	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							15	16	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	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)					835	312	4,641	1
2	HMO and other (see instructions)					181	4,143		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	20.00	592.88			835	312	4,641	14
15	CAH Visits								15
16	Subprovider - IPF					372	139	2,070	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	20.00	592.88						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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HOSPITAL WAGE INDEX INFORMATION**WORKSHEET S-3
PARTS II-III****Part II - Wage Data**

		Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)	
		1	2	3	4	5	6	
	SALARIES							
1	Total salaries (see instructions)	200	35,191,203		35,191,203	1,233,183.00	28.54	1
2	Non-physician anesthetist Part A							2
3	Non-physician anesthetest Part B							3
4	Physician-Part A - Administrative							4
4.01	Physician-Part A - Teaching							4.01
5	Physician-Part B							5
6	Non-physician-Part B							6
7	Interns & residents (in an approved program)	21	986,905		986,905	38,950.00	25.34	7
7.01	Contracted interns & residents (in an approved program)							7.01
8	Home office and/or related organization personnel							8
9	SNF	44						9
10	Excluded area salaries (see instructions)		4,874,957		4,874,957	45,445.00	107.27	10
	OTHER WAGES & RELATED COSTS							
11	Contract labor (see instructions)		4,978,669		4,978,669	74,252.00	67.05	11
12	Contract management and administrative services							12
13	Contract labor: Physician-Part A - Administrative							13
14	Home office salaries & wage-related costs							14
14.01	Home office salaries							14.01
14.02	Related organization salaries							14.02
15	Home office: Physician Part A - Administrative							15
16	Home office & Contract Physicians Part A - Teaching							16
	WAGE-RELATED COSTS							
17	Wage-related costs (core)(see instructions)		6,597,355		6,597,355			17
18	Wage-related costs (other)(see instructions)							18
19	Excluded areas		318,929		318,929			19
20	Non-physician anesthetist Part A							20
21	Non-physician anesthetist Part B							21
22	Physician Part A - Administrative							22
22.01	Physician Part A - Teaching							22.01
23	Physician Part B							23
24	Wage-related costs (RHC/FQHC)							24
25	Interns & residents (in an approved program)		221,240		221,240			25
25.50	Home office wage-related							25.50
25.51	Related organization wage-related							25.51
25.52	Home office: Physician Part A - Administrative - wage-related							25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related							25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26	Employee Benefits Department		173,824		173,824	9,776.00	17.78	26
27	Administrative & General		7,049,143		7,049,143	187,292.00	37.64	27
28	Administrative & General under contract (see instructions)		25,595		25,595	124.00	206.41	28
29	Maintenance & Repairs		540,301		540,301	16,012.00	33.74	29
30	Operation of Plant		610,375		610,375	41,177.00	14.82	30
31	Laundry & Linen Service							31
32	Housekeeping		962,998		962,998	64,138.00	15.01	32
33	Housekeeping under contract (see instructions)							33
34	Dietary		867,442	-341,665	525,777	32,078.00	16.39	34
35	Dietary under contract (see instructions)							35
36	Cafeteria			341,665	341,665	20,758.00	16.46	36
37	Maintenance of Personnel							37
38	Nursing Administration		1,323,033		1,323,033	42,730.00	30.96	38
39	Central Services and Supply		57,677		57,677	4,234.00	13.62	39
40	Pharmacy		800,239		800,239	21,892.00	36.55	40
41	Medical Records & Medical Records Library		712,498		712,498	37,715.00	18.89	41
42	Social Service		150,192		150,192	7,581.00	19.81	42
43	Other General Service							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)		34,229,893		34,229,893	1,194,357.00	28.66	1
2	Excluded area salaries (see instructions)		4,874,957		4,874,957	45,445.00	107.27	2
3	Subtotal salaries (line 1 minus line 2)		29,354,936		29,354,936	1,148,912.00	25.55	3
4	Subtotal other wages & related costs (see instructions)		4,978,669		4,978,669	74,252.00	67.05	4
5	Subtotal wage-related costs (see instructions)		6,597,355		6,597,355		22.47%	5
6	Total (sum of lines 3 through 5)		40,930,960		40,930,960	1,223,164.00	33.46	6
7	Total overhead cost (see instructions)		13,273,317		13,273,317	485,507.00	27.34	7

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HOSPITAL WAGE RELATED COSTS**WORKSHEET S-3
PART IV****Part IV - Wage Related Cost****Part A - Core List**

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions	878,318	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	2,793,039	8.02
8.03	Health Insurance (Purchased)		8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan		10
11	Life Insurance (If employee is owner or beneficiary)	111,551	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)		13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	723,199	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	2,608,915	17
18	Medicare Taxes - Employers Portion Only		18
19	Unemployment Insurance		19
20	State or Federal Unemployment Taxes	22,501	20
	OTHER		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement		23
24	Total Wage Related cost (Sum of lines 1-23)	7,137,523	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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KPMG LLP Compu-Max 2552-10

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

	Component	Contract Labor	Benefit Cost	
	0	1	2	
1	Total facility contract labor and benefit cost	4,361,925	7,137,523	1
2	Hospital	4,361,925	7,137,523	2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA**WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.257151	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	38,248,052	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	106,641,335	6
7	Medicaid cost (line 1 times line 6)	27,422,926	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,226,576	11,176,064	14,402,640	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	829,717	11,176,064	12,005,781	21
22	Payments received from patients for amounts previously written off as charity care		180	180	22
23	Cost of charity care (line 21 minus line 22)	829,717	11,175,884	12,005,601	23

24	Does the amount in 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
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	15,422,590	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	543,351	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	835,924	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	14,586,666	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	4,043,549	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	16,049,150	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	16,049,150	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt				4,021,700	4,021,700	-60,707	3,960,993	1
2	00200	Cap Rel Costs-Mvble Equip								2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	173,824	59,762	233,586	7,153,549	7,387,135	-315	7,386,820	4
5	00500	Administrative & General	7,049,143	25,136,247	32,185,390	-11,155,423	21,029,967	-9,435,169	11,594,798	5
6	00600	Maintenance & Repairs	540,301	301,470	841,771		841,771		841,771	6
7	00700	Operation of Plant	610,375	2,334,763	2,945,138		2,945,138	-614,557	2,330,581	7
8	00800	Laundry & Linen Service		355,422	355,422		355,422		355,422	8
9	00900	Housekeeping	962,998	322,532	1,285,530	-19,826	1,265,704		1,265,704	9
10	01000	Dietary	867,442	813,621	1,681,063	-662,131	1,018,932		1,018,932	10
11	01100	Cafeteria		23,369	23,369	662,131	685,500	-265,045	420,455	11
12	01200	Maintenance of Personnel		-4,320	-4,320		-4,320	4,320		12
13	01300	Nursing Administration	1,323,033	205,784	1,528,817		1,528,817		1,528,817	13
14	01400	Central Services & Supply	57,677	108,119	165,796	-28,861	136,935		136,935	14
15	01500	Pharmacy	800,239	1,740,927	2,541,166	-1,837,651	703,515		703,515	15
16	01600	Medical Records & Library	712,498	129,624	842,122		842,122	-6,203	835,919	16
17	01700	Social Service	150,192		150,192		150,192		150,192	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	986,905		986,905		986,905	-45,392	941,513	21
22	02200	I&R Services-Other Prgm Costs Apprvd		77,452	77,452		77,452		77,452	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	6,739,627	2,802,225	9,541,852	-28,234	9,513,618	-394,330	9,119,288	30
31	03100	Intensive Care Unit	1,190,964	1,004,958	2,195,922		2,195,922	-43,750	2,152,172	31
40	04000	Subprovider - IPF	1,174,913	809,111	1,984,024		1,984,024		1,984,024	40
43	04300	Nursery	619,202	520,253	1,139,455		1,139,455	-492,917	646,538	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	1,019,742	713,352	1,733,094	-621,875	1,111,219		1,111,219	50
52	05200	Delivery Room & Labor Room	1,367,025	348,838	1,715,863		1,715,863		1,715,863	52
54	05400	Radiology-Diagnostic	920,120	936,820	1,856,940	-17,168	1,839,772	-825,000	1,014,772	54
55.01	03190	CHEMO THERAPY				28,234	28,234		28,234	55.01
56	05600	Radioisotope	164,701	144,557	309,258		309,258		309,258	56
57	05700	CT Scan	310,103	89,976	400,079		400,079		400,079	57
60	06000	Laboratory		3,961,621	3,961,621		3,961,621	-2,083	3,959,538	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	840,128	272,325	1,112,453		1,112,453	-18,750	1,093,703	65
66	06600	Physical Therapy	270,922	189,849	460,771		460,771		460,771	66
69	06900	Electrocardiology	247,561	3,589	251,150		251,150		251,150	69
71	07100	Medical Supplies Charged to Patients				385,891	385,891		385,891	71
72	07200	Impl. Dev. Charged to Patients				282,013	282,013		282,013	72
73	07300	Drugs Charged to Patients				1,837,651	1,837,651		1,837,651	73
74	07400	Renal Dialysis		349,083	349,083		349,083		349,083	74
76	03550	OP PSYCH	161,801	2,349	164,150		164,150		164,150	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
91	09100	Emergency	2,229,723	4,614,707	6,844,430		6,844,430	-1,470,000	5,374,430	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.01	04950	CANCER CENTER								93.01
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	31,491,159	48,368,385	79,859,544		79,859,544	-13,669,898	66,189,646	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	3,582,993	704,855	4,287,848		4,287,848		4,287,848	192
194	07950	OTHER NON REIMBURSEABLE COST CENTER	117,051	131,958	249,009		249,009		249,009	194
200		TOTAL (sum of lines 118-199)	35,191,203	49,205,198	84,396,401		84,396,401	-13,669,898	70,726,503	200

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRECIATION EXPENSE	A	Cap Rel Costs-Bldg & Fixt	1		3,416,306	1
500	Total reclassifications					3,416,306	500
	Code Letter - A						
1	FRINGE BENEFITS	B	Employee Benefits Department	4		7,153,549	1
2							2
500	Total reclassifications					7,153,549	500
	Code Letter - B						
1	INTEREST	C	Cap Rel Costs-Bldg & Fixt	1		513,233	1
500	Total reclassifications					513,233	500
	Code Letter - C						
1	CAFETERIA	D	Cafeteria	11	341,665	320,466	1
500	Total reclassifications				341,665	320,466	500
	Code Letter - D						
1	CENTRAL SUPPLY AND IMPLANTS	E	Medical Supplies Charged to P	71		385,891	1
2			Impl. Dev. Charged to Patient	72		282,013	2
3							3
500	Total reclassifications					667,904	500
	Code Letter - E						
1	CHARGEABLE DRUGS	F	Drugs Charged to Patients	73		1,837,651	1
500	Total reclassifications					1,837,651	500
	Code Letter - F						
1	CHEMO THERAPY	G	CHEMO THERAPY	55.01	24,127	4,107	1
500	Total reclassifications				24,127	4,107	500
	Code Letter - G						
1	CAPITAL INSURANCE	H	Cap Rel Costs-Bldg & Fixt	1		92,161	1
500	Total reclassifications					92,161	500
	Code Letter - H						
	GRAND TOTAL (Increases)				365,792	14,005,377	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRECIATION EXPENSE	A	Administrative & General	5		3,416,306	9	1
500	Total reclassifications					3,416,306		500
	Code letter - A							
1	FRINGE BENEFITS	B	Administrative & General	5		7,133,723		1
2			Housekeeping	9		19,826		2
500	Total reclassifications					7,153,549		500
	Code letter - B							
1	INTEREST	C	Administrative & General	5		513,233	11	1
500	Total reclassifications					513,233		500
	Code letter - C							
1	CAFETERIA	D	Dietary	10	341,665	320,466		1
500	Total reclassifications				341,665	320,466		500
	Code letter - D							
1	CENTRAL SUPPLY AND IMPLANTS	E	Central Services & Supply	14		28,861		1
2			Operating Room	50		621,875		2
3			Radiology-Diagnostic	54		17,168		3
500	Total reclassifications					667,904		500
	Code letter - E							
1	CHARGEABLE DRUGS	F	Pharmacy	15		1,837,651		1
500	Total reclassifications					1,837,651		500
	Code letter - F							
1	CHEMO THERAPY	G	Adults & Pediatrics	30	24,127	4,107		1
500	Total reclassifications				24,127	4,107		500
	Code letter - G							
1	CAPITAL INSURANCE	H	Administrative & General	5		92,161	9	1
500	Total reclassifications					92,161		500
	Code letter - H							
	GRAND TOTAL (Decreases)				365,792	14,005,377		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

		Acquisitions							
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	2,482,024					2,482,024		1
2	Land Improvements	629,240					629,240		2
3	Buildings and Fixtures	40,295,847	6,269		6,269		40,302,116		3
4	Building Improvements	13,642,969	6,649		6,649		13,649,618		4
5	Fixed Equipment								5
6	Movable Equipment	32,011,765	1,202,417		1,202,417		33,214,182		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	89,061,845	1,215,335		1,215,335		90,277,180		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	89,061,845	1,215,335		1,215,335		90,277,180		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt								1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)								3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	53,951,734		53,951,734	0.618954					1
2	Cap Rel Costs-Mvble Equip	33,214,182		33,214,182	0.381046					2
3	Total (sum of lines 1-2)	87,165,916		87,165,916	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	3,508,467		452,526				3,960,993	1
2	Cap Rel Costs-Mvble Equip								2
3	Total (sum of lines 1-2)	3,508,467		452,526				3,960,993	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	A	-60,707	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-52,586	Administrative & General	5		7
8	Television and radio service (chapter 21)	A	-8,925	Administrative & General	5		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-3,292,222				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-264,992	Cafeteria	11		14
15	Rental of quarters to employees & others	B	-219,750	Operation of Plant	7		15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-6,203	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-53	Cafeteria	11		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
34							34
35							35
36							36
36.03	LOCKER & ID REVENUE	B	-315	Employee Benefits Department	4		36.03
36.05	CLERICAL FEES	B	-21	Administrative & General	5		36.05
36.06	DIALYSIS RENT	B	-216,275	Operation of Plant	7	9	36.06
36.20	DOCTOR'S OFFICE RENTALS	B	-178,532	Operation of Plant	7	9	36.20
37	LOBBYING DUES	A	-38,056	Administrative & General	5		37
38	ZERO OUT NEGATIVE EXP	A	4,320	Maintenance of Personnel	12		38
39							39
40	PROVIDER TAX PROCEEDS	B	-9,072,722	Administrative & General	5		40
41	MISC REV	B	-262,859	Administrative & General	5		41
42							42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-13,669,898				50

(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.

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

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS
OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
	1	2	3	Name	Percentage of Ownership	Type of Business	
6				4	5	6	6
7							7
8							8
9							9
10							10

- (1) Use the following symbols to indicate the 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.

G. Other (financial Or non-financial) specify:

KPMG LLP Compu-Max 2552-10

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	21	I&R Services-Salary AGGREGATE	45,494		45,494	211,500	1	102	5	1
2										2
3	30	Adults & Pediatrics AGGREGATE	394,330	394,330						3
4	31	Intensive Care Unit AGGREGATE	43,750	43,750						4
5	43	Nursery	492,917	492,917						5
6										6
7										7
8	54	Radiology-Diagnostic AGGREGATE	825,000	825,000						8
9	60	Laboratory AGGREGATE	2,083	2,083						9
10	65	Respiratory Therapy AGGREGATE	18,750	18,750						10
11										11
12	91	Emergency AGGREGATE	1,470,000	1,470,000						12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	3,292,324	3,246,830	45,494		1	102	5	200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	21	I&R Services-Salary AGGREGATE					102	45,392	45,392	1
2										2
3	30	Adults & Pediatrics AGGREGATE							394,330	3
4	31	Intensive Care Unit AGGREGATE							43,750	4
5	43	Nursery							492,917	5
6										6
7										7
8	54	Radiology-Diagnostic AGGREGATE							825,000	8
9	60	Laboratory AGGREGATE							2,083	9
10	65	Respiratory Therapy AGGREGATE							18,750	10
11										11
12	91	Emergency AGGREGATE							1,470,000	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL					102	45,392	3,292,222	200

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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		0	1	4	4A	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,960,993	3,960,993					1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	7,386,820	17,663	7,404,483				4
5	Administrative & General	11,594,798	218,832	1,490,543	13,304,173	13,304,173		5
6	Maintenance & Repairs	841,771	42,315	114,248	998,334	231,304	1,229,638	6
7	Operation of Plant	2,330,581	942,512	129,065	3,402,158	788,246	314,748	7
8	Laundry & Linen Service	355,422	15,472		370,894	85,932	5,167	8
9	Housekeeping	1,265,704	50,734	203,628	1,520,066	352,184	16,942	9
10	Dietary	1,018,932	57,541	111,177	1,187,650	275,167	19,215	10
11	Cafeteria	420,455	40,226	72,246	532,927	123,474	13,433	11
12	Maintenance of Personnel		47,188		47,188	10,933	15,758	12
13	Nursing Administration	1,528,817	24,767	279,758	1,833,342	424,767	8,271	13
14	Central Services & Supply	136,935	57,425	12,196	206,556	47,857	19,177	14
15	Pharmacy	703,515	23,568	169,212	896,295	207,663	7,870	15
16	Medical Records & Library	835,919	58,237	150,659	1,044,815	242,073	19,448	16
17	Social Service	150,192	19,249	31,758	201,199	46,616	6,428	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	941,513		208,683	1,150,196	266,489		21
22	I&R Services-Other Prgm Costs Apprvd	77,452	8,986		86,438	20,027	3,001	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,119,288	522,267	1,420,006	11,061,561	2,562,846	174,407	30
31	Intensive Care Unit	2,152,172	41,128	251,832	2,445,132	566,513	13,735	31
40	Subprovider - IPF	1,984,024	419,768	248,438	2,652,230	614,495	140,178	40
43	Nursery	646,538	15,007	130,932	792,477	183,609	5,012	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,111,219	172,443	215,626	1,499,288	347,370	57,586	50
52	Delivery Room & Labor Room	1,715,863	17,999	289,060	2,022,922	468,691	6,010	52
54	Radiology-Diagnostic	1,014,772	126,918	194,561	1,336,251	309,596	42,383	54
55.01	CHEMO THERAPY	28,234		5,102	33,336	7,724		55.01
56	Radioisotope	309,258	21,493	34,826	365,577	84,701	7,177	56
57	CT Scan	400,079	9,064	65,572	474,715	109,987	3,027	57
60	Laboratory	3,959,538	47,330		4,006,868	928,351	15,805	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,093,703	37,029	177,647	1,308,379	303,138	12,365	65
66	Physical Therapy	460,771	49,767	57,287	567,825	131,559	16,619	66
69	Electrocardiology	251,150		52,347	303,497	70,317		69
71	Medical Supplies Charged to Patients	385,891			385,891	89,407		71
72	Impl. Dev. Charged to Patients	282,013			282,013	65,340		72
73	Drugs Charged to Patients	1,837,651			1,837,651	425,765		73
74	Renal Dialysis	349,083	124,339		473,422	109,687	41,522	74
76	OP PSYCH	164,150	27,991	34,213	226,354	52,444	9,347	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	5,374,430	77,731	471,479	5,923,640	1,372,448	25,958	91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	66,189,646	3,334,989	6,622,101	64,781,260	11,926,720	1,020,589	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,287,848	626,004	757,631	5,671,483	1,314,026	209,049	192
194	OTHER NON REIMBURSEABLE COST CENTER	249,009		24,751	273,760	63,427		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	70,726,503	3,960,993	7,404,483	70,726,503	13,304,173	1,229,638	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	4,505,152						7
8	Laundry & Linen Service	25,442	487,435					8
9	Housekeeping	83,427		1,972,619				9
10	Dietary	94,621		42,457	1,619,110			10
11	Cafeteria	66,148		29,681	637,733	1,403,396		11
12	Maintenance of Personnel	77,597		34,818			186,294	12
13	Nursing Administration	40,728		18,275		69,560	35,150	13
14	Central Services & Supply	94,431		42,371		6,909		14
15	Pharmacy	38,756		17,390		35,627		15
16	Medical Records & Library	95,766		42,971		61,399		16
17	Social Service	31,654		14,203		12,327		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					63,431		21
22	I&R Services-Other Prgm Costs Apprvd	14,777		6,631				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	858,823	250,198	385,355	523,243	327,886	115,994	30
31	Intensive Care Unit	67,632	34,933	30,347	37,576	62,821		31
40	Subprovider - IPF	690,272	201,099	309,726	420,558	263,543		40
43	Nursery	24,678	1,205	11,073		22,114	35,150	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	283,568		127,237		48,394		50
52	Delivery Room & Labor Room	29,597		13,280		57,402		52
54	Radiology-Diagnostic	208,706		93,647		44,161		54
55.01	CHEMO THERAPY					1,524		55.01
56	Radioisotope	35,343		15,858		6,468		56
57	CT Scan	14,905		6,688		17,475		57
60	Laboratory	77,830		34,922				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	60,890		27,322		46,532		65
66	Physical Therapy	81,837		36,720		10,668		66
69	Electrocardiology					10,431		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	204,465		91,744				74
76	OP PSYCH	46,028		20,653		10,194		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	127,823		57,354		150,533		91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,475,744	487,435	1,510,723	1,619,110	1,329,399	186,294	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	1,029,408		461,896		60,146		192
194	OTHER NON REIMBURSEABLE COST CENTER					13,851		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,505,152	487,435	1,972,619	1,619,110	1,403,396	186,294	202

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COST ALLOCATION - GENERAL SERVICE COSTS
**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	
		13	14	15	16	17	21	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	2,430,093						13
14	Central Services & Supply		417,301					14
15	Pharmacy			1,203,601				15
16	Medical Records & Library				1,506,472			16
17	Social Service					312,427		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd						1,480,116	21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	854,296	40,097	8,894	773,524	160,421	1,148,904	30
31	Intensive Care Unit	163,677	48,757	2,840	107,527	22,300	48,518	31
40	Subprovider - IPF	686,648	32,228	7,148	621,713	128,937		40
43	Nursery	57,618	5,486		3,708	769	49,811	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	126,088		1,675			98,329	50
52	Delivery Room & Labor Room	149,559	7,055					52
54	Radiology-Diagnostic						15,525	54
55.01	CHEMO THERAPY							55.01
56	Radioisotope		27,142					56
57	CT Scan		5,847					57
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		16,916				69,218	65
66	Physical Therapy		359					66
69	Electrocardiology		440					69
71	Medical Supplies Charged to Patients		90,650					71
72	Impl. Dev. Charged to Patients		66,247					72
73	Drugs Charged to Patients			1,113,886				73
74	Renal Dialysis		1,087					74
76	OP PSYCH		230					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	392,207	74,760	1,230			49,811	91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,430,093	417,301	1,135,673	1,506,472	312,427	1,480,116	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			67,928				192
194	OTHER NON REIMBURSEABLE COST CENTER							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,430,093	417,301	1,203,601	1,506,472	312,427	1,480,116	202

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COST ALLOCATION - GENERAL SERVICE COSTS**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		22	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd	130,874					22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	101,584	19,348,033	-1,250,488	18,097,545		30
31	Intensive Care Unit	4,292	3,656,600	-52,810	3,603,790		31
40	Subprovider - IPF		6,768,775		6,768,775		40
43	Nursery	4,404	1,197,114	-54,215	1,142,899		43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	8,696	2,598,231	-107,025	2,491,206		50
52	Delivery Room & Labor Room		2,754,516		2,754,516		52
54	Radiology-Diagnostic	1,375	2,051,644	-16,900	2,034,744		54
55.01	CHEMO THERAPY		42,584		42,584		55.01
56	Radioisotope		542,266		542,266		56
57	CT Scan		632,644		632,644		57
60	Laboratory		5,063,776		5,063,776		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	6,119	1,850,879	-75,337	1,775,542		65
66	Physical Therapy		845,587		845,587		66
69	Electrocardiology		384,685		384,685		69
71	Medical Supplies Charged to Patients		565,948		565,948		71
72	Impl. Dev. Charged to Patients		413,600		413,600		72
73	Drugs Charged to Patients		3,377,302		3,377,302		73
74	Renal Dialysis		921,927		921,927		74
76	OP PSYCH		365,250		365,250		76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	4,404	8,180,168	-54,215	8,125,953		91
92	Observation Beds (Non-Distinct Part)						92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	130,874	61,561,529	-1,610,990	59,950,539		118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices		8,813,936		8,813,936		192
194	OTHER NON REIMBURSEABLE COST CENTER		351,038		351,038		194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	130,874	70,726,503	-1,610,990	69,115,513		202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		0	1	2A	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		17,663	17,663	17,663			4
5	Administrative & General	76,440	218,832	295,272	3,567	298,839		5
6	Maintenance & Repairs	8,769	42,315	51,084	272	5,195	56,551	6
7	Operation of Plant		942,512	942,512	308	17,705	14,475	7
8	Laundry & Linen Service		15,472	15,472		1,930	238	8
9	Housekeeping		50,734	50,734	485	7,910	779	9
10	Dietary		57,541	57,541	265	6,181	884	10
11	Cafeteria		40,226	40,226	172	2,773	618	11
12	Maintenance of Personnel		47,188	47,188		246	725	12
13	Nursing Administration		24,767	24,767	667	9,541	380	13
14	Central Services & Supply	44,481	57,425	101,906	29	1,075	882	14
15	Pharmacy	1,218	23,568	24,786	403	4,664	362	15
16	Medical Records & Library		58,237	58,237	359	5,437	894	16
17	Social Service		19,249	19,249	76	1,047	296	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				497	5,986		21
22	I&R Services-Other Prgm Costs Apprvd		8,986	8,986		450	138	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,448	522,267	529,715	3,385	57,579	8,021	30
31	Intensive Care Unit	3,039	41,128	44,167	600	12,724	632	31
40	Subprovider - IPF		419,768	419,768	592	13,802	6,447	40
43	Nursery		15,007	15,007	312	4,124	230	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,682	172,443	177,125	514	7,802	2,648	50
52	Delivery Room & Labor Room		17,999	17,999	689	10,527	276	52
54	Radiology-Diagnostic		126,918	126,918	464	6,954	1,949	54
55.01	CHEMO THERAPY				12	173		55.01
56	Radioisotope		21,493	21,493	83	1,902	330	56
57	CT Scan	11,000	9,064	20,064	156	2,470	139	57
60	Laboratory		47,330	47,330		20,852	727	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,641	37,029	50,670	423	6,809	569	65
66	Physical Therapy		49,767	49,767	137	2,955	764	66
69	Electrocardiology				125	1,579		69
71	Medical Supplies Charged to Patients					2,008		71
72	Impl. Dev. Charged to Patients					1,468		72
73	Drugs Charged to Patients					9,563		73
74	Renal Dialysis		124,339	124,339		2,464	1,910	74
76	OP PSYCH		27,991	27,991	82	1,178	430	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	14,404	77,731	92,135	1,124	30,827	1,194	91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	185,122	3,334,989	3,520,111	15,798	267,900	46,937	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		626,004	626,004	1,806	29,514	9,614	192
194	OTHER NON REIMBURSEABLE COST CENTER	52,167		52,167	59	1,425		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	237,289	3,960,993	4,198,282	17,663	298,839	56,551	202

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ALLOCATION OF CAPITAL-RELATED COSTS**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	975,000						7
8	Laundry & Linen Service	5,506	23,146					8
9	Housekeeping	18,055		77,963				9
10	Dietary	20,478		1,678	87,027			10
11	Cafeteria	14,316		1,173	34,278	93,556		11
12	Maintenance of Personnel	16,793		1,376			66,328	12
13	Nursing Administration	8,814		722		4,637	12,515	13
14	Central Services & Supply	20,437		1,675		461		14
15	Pharmacy	8,388		687		2,375		15
16	Medical Records & Library	20,726		1,698		4,093		16
17	Social Service	6,850		561		822		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					4,229		21
22	I&R Services-Other Prgm Costs Apprvd	3,198		262				22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	185,865	11,881	15,230	28,124	21,857	41,298	30
31	Intensive Care Unit	14,637	1,659	1,199	2,020	4,188		31
40	Subprovider - IPF	149,388	9,549	12,241	22,605	17,569		40
43	Nursery	5,341	57	438		1,474	12,515	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	61,369		5,029		3,226		50
52	Delivery Room & Labor Room	6,405		525		3,827		52
54	Radiology-Diagnostic	45,168		3,701		2,944		54
55.01	CHEMO THERAPY					102		55.01
56	Radioisotope	7,649		627		431		56
57	CT Scan	3,226		264		1,165		57
60	Laboratory	16,844		1,380				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,178		1,080		3,102		65
66	Physical Therapy	17,711		1,451		711		66
69	Electrocardiology					695		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis	44,250		3,626				74
76	OP PSYCH	9,961		816		680		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	27,663		2,267		10,035		91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	752,216	23,146	59,706	87,027	88,623	66,328	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	222,784		18,257		4,010		192
194	OTHER NON REIMBURSEABLE COST CENTER					923		194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	975,000	23,146	77,963	87,027	93,556	66,328	202

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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I&R SALARY & FRINGES	
		13	14	15	16	17	21	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	62,043						13
14	Central Services & Supply		126,465					14
15	Pharmacy			41,665				15
16	Medical Records & Library				91,444			16
17	Social Service					28,901		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd						10,712	21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,812	12,152	308	46,954	14,840		30
31	Intensive Care Unit	4,179	14,776	98	6,527	2,063		31
40	Subprovider - IPF	17,531	9,767	247	37,738	11,927		40
43	Nursery	1,471	1,662		225	71		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,219		58				50
52	Delivery Room & Labor Room	3,818	2,138					52
54	Radiology-Diagnostic							54
55.01	CHEMO THERAPY							55.01
56	Radioisotope		8,225					56
57	CT Scan		1,772					57
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,126					65
66	Physical Therapy		109					66
69	Electrocardiology		133					69
71	Medical Supplies Charged to Patients		27,473					71
72	Impl. Dev. Charged to Patients		20,077					72
73	Drugs Charged to Patients			38,560				73
74	Renal Dialysis		329					74
76	OP PSYCH		70					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	10,013	22,656	43				91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	62,043	126,465	39,314	91,444	28,901		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			2,351				192
194	OTHER NON REIMBURSEABLE COST CENTER							194
200	Cross Foot Adjustments						10,712	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	62,043	126,465	41,665	91,444	28,901	10,712	202

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	I&R PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		22	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd	13,034						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		999,021		999,021			30
31	Intensive Care Unit		109,469		109,469			31
40	Subprovider - IPF		729,171		729,171			40
43	Nursery		42,927		42,927			43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		260,990		260,990			50
52	Delivery Room & Labor Room		46,204		46,204			52
54	Radiology-Diagnostic		188,098		188,098			54
55.01	CHEMO THERAPY		287		287			55.01
56	Radioisotope		40,740		40,740			56
57	CT Scan		29,256		29,256			57
60	Laboratory		87,133		87,133			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		80,957		80,957			65
66	Physical Therapy		73,605		73,605			66
69	Electrocardiology		2,532		2,532			69
71	Medical Supplies Charged to Patients		29,481		29,481			71
72	Impl. Dev. Charged to Patients		21,545		21,545			72
73	Drugs Charged to Patients		48,123		48,123			73
74	Renal Dialysis		176,918		176,918			74
76	OP PSYCH		41,208		41,208			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		197,957		197,957			91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		3,205,622		3,205,622			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		914,340		914,340			192
194	OTHER NON REIMBURSEABLE COST CENTER		54,574		54,574			194
200	Cross Foot Adjustments	13,034	23,746		23,746			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,034	4,198,282		4,198,282			202

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		1	4	5A	5	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	307,222						1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department	1,370	35,017,379					4
5	Administrative & General	16,973	7,049,143	-13,304,173	57,422,330			5
6	Maintenance & Repairs	3,282	540,301		998,334	285,597		6
7	Operation of Plant	73,103	610,375		3,402,158	73,103	212,494	7
8	Laundry & Linen Service	1,200			370,894	1,200	1,200	8
9	Housekeeping	3,935	962,998		1,520,066	3,935	3,935	9
10	Dietary	4,463	525,777		1,187,650	4,463	4,463	10
11	Cafeteria	3,120	341,665		532,927	3,120	3,120	11
12	Maintenance of Personnel	3,660			47,188	3,660	3,660	12
13	Nursing Administration	1,921	1,323,033		1,833,342	1,921	1,921	13
14	Central Services & Supply	4,454	57,677		206,556	4,454	4,454	14
15	Pharmacy	1,828	800,239		896,295	1,828	1,828	15
16	Medical Records & Library	4,517	712,498		1,044,815	4,517	4,517	16
17	Social Service	1,493	150,192		201,199	1,493	1,493	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		986,905		1,150,196			21
22	I&R Services-Other Prgm Costs Apprvd	697			86,438	697	697	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	40,508	6,715,500		11,061,561	40,508	40,508	30
31	Intensive Care Unit	3,190	1,190,964		2,445,132	3,190	3,190	31
40	Subprovider - IPF	32,558	1,174,913		2,652,230	32,558	32,558	40
43	Nursery	1,164	619,202		792,477	1,164	1,164	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,375	1,019,742		1,499,288	13,375	13,375	50
52	Delivery Room & Labor Room	1,396	1,367,025		2,022,922	1,396	1,396	52
54	Radiology-Diagnostic	9,844	920,120		1,336,251	9,844	9,844	54
55.01	CHEMO THERAPY		24,127		33,336			55.01
56	Radioisotope	1,667	164,701		365,577	1,667	1,667	56
57	CT Scan	703	310,103		474,715	703	703	57
60	Laboratory	3,671			4,006,868	3,671	3,671	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,872	840,128		1,308,379	2,872	2,872	65
66	Physical Therapy	3,860	270,922		567,825	3,860	3,860	66
69	Electrocardiology		247,561		303,497			69
71	Medical Supplies Charged to Patients				385,891			71
72	Impl. Dev. Charged to Patients				282,013			72
73	Drugs Charged to Patients				1,837,651			73
74	Renal Dialysis	9,644			473,422	9,644	9,644	74
76	OP PSYCH	2,171	161,801		226,354	2,171	2,171	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	6,029	2,229,723		5,923,640	6,029	6,029	91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	258,668	31,317,335	-13,304,173	51,477,087	237,043	163,940	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	48,554	3,582,993		5,671,483	48,554	48,554	192
194	OTHER NON REIMBURSEABLE COST CENTER		117,051		273,760			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,960,993	7,404,483		13,304,173	1,229,638	4,505,152	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.892934	0.211452		0.231690	4.305500	21.201314	203
204	Cost to be allocated (Per Wkst. B, Part II)		17,663		298,839	56,551	975,000	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.000504		0.005204	0.198010	4.588365	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY + LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS SERVED	CAFETERIA FTES SERVED	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION FTES SERVED	
		8	9	10	11	12	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	28,730						8
9	Housekeeping		207,359					9
10	Dietary		4,463	93,676				10
11	Cafeteria		3,120	36,897	41,440			11
12	Maintenance of Personnel		3,660			53		12
13	Nursing Administration		1,921		2,054	10	27,541	13
14	Central Services & Supply		4,454		204			14
15	Pharmacy		1,828		1,052			15
16	Medical Records & Library		4,517		1,813			16
17	Social Service		1,493		364			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				1,873			21
22	I&R Services-Other Prgm Costs Apprvd		697					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,747	40,508	30,273	9,682	33	9,682	30
31	Intensive Care Unit	2,059	3,190	2,174	1,855		1,855	31
40	Subprovider - IPF	11,853	32,558	24,332	7,782		7,782	40
43	Nursery	71	1,164		653	10	653	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		13,375		1,429		1,429	50
52	Delivery Room & Labor Room		1,396		1,695		1,695	52
54	Radiology-Diagnostic		9,844		1,304			54
55.01	CHEMO THERAPY				45			55.01
56	Radioisotope		1,667		191			56
57	CT Scan		703		516			57
60	Laboratory		3,671					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,872		1,374			65
66	Physical Therapy		3,860		315			66
69	Electrocardiology				308			69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis		9,644					74
76	OP PSYCH		2,171		301			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency		6,029		4,445		4,445	91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	28,730	158,805	93,676	39,255	53	27,541	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		48,554		1,776			192
194	OTHER NON REIMBURSEABLE COST CENTER				409			194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	487,435	1,972,619	1,619,110	1,403,396	186,294	2,430,093	202
203	Unit Cost Multiplier (Wkst. B, Part I)	16.966063	9.513062	17.284150	33.865734	3,514.981132	88.235467	203
204	Cost to be allocated (Per Wkst. B, Part II)	23,146	77,963	87,027	93,556	66,328	62,043	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.805639	0.375981	0.929021	2.257625	1,251.471698	2.252750	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY PATIENT DAYS	SOCIAL SERVICE PATIENT DAYS	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
		14	15	16	17	21	22	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	1,776,435						14
15	Pharmacy		1,819,185					15
16	Medical Records & Library			28,847				16
17	Social Service				28,847			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					674,134		21
22	I&R Services-Other Prgm Costs Apprvd						28,083	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	170,692	13,443	14,812	14,812	523,280	21,798	30
31	Intensive Care Unit	207,558	4,292	2,059	2,059	22,098	921	31
40	Subprovider - IPF	137,192	10,804	11,905	11,905			40
43	Nursery	23,352		71	71	22,687	945	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,532			44,785	1,866	50
52	Delivery Room & Labor Room	30,035						52
54	Radiology-Diagnostic					7,071	295	54
55.01	CHEMO THERAPY							55.01
56	Radioisotope	115,541						56
57	CT Scan	24,891						57
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	72,009				31,526	1,313	65
66	Physical Therapy	1,529						66
69	Electrocardiology	1,871						69
71	Medical Supplies Charged to Patients	385,891						71
72	Impl. Dev. Charged to Patients	282,013						72
73	Drugs Charged to Patients		1,683,585					73
74	Renal Dialysis	4,628						74
76	OP PSYCH	980						76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	318,253	1,859			22,687	945	91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,776,435	1,716,515	28,847	28,847	674,134	28,083	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		102,670					192
194	OTHER NON REIMBURSEABLE COST CENTER							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	417,301	1,203,601	1,506,472	312,427	1,480,116	130,874	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.234909	0.661616	52.222831	10.830485	2.195581	4.660257	203
204	Cost to be allocated (Per Wkst. B, Part II)	126,465	41,665	91,444	28,901	10,712	13,034	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.071190	0.022903	3.169966	1.001872	0.015890	0.464124	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55.01	CHEMO THERAPY							55.01
56	Radioisotope							56
57	CT Scan							57
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	OP PSYCH							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	OTHER NON REIMBURSEABLE COST CENTER							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	18,097,545		18,097,545		18,097,545	30
31	Intensive Care Unit	3,603,790		3,603,790		3,603,790	31
40	Subprovider - IPF	6,768,775		6,768,775		6,768,775	40
43	Nursery	1,142,899		1,142,899		1,142,899	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,491,206		2,491,206		2,491,206	50
52	Delivery Room & Labor Room	2,754,516		2,754,516		2,754,516	52
54	Radiology-Diagnostic	2,034,744		2,034,744		2,034,744	54
55.01	CHEMO THERAPY	42,584		42,584		42,584	55.01
56	Radioisotope	542,266		542,266		542,266	56
57	CT Scan	632,644		632,644		632,644	57
60	Laboratory	5,063,776		5,063,776		5,063,776	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,775,542		1,775,542		1,775,542	65
66	Physical Therapy	845,587		845,587		845,587	66
69	Electrocardiology	384,685		384,685		384,685	69
71	Medical Supplies Charged to Patients	565,948		565,948		565,948	71
72	Impl. Dev. Charged to Patients	413,600		413,600		413,600	72
73	Drugs Charged to Patients	3,377,302		3,377,302		3,377,302	73
74	Renal Dialysis	921,927		921,927		921,927	74
76	OP PSYCH	365,250		365,250		365,250	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	8,125,953		8,125,953		8,125,953	91
92	Observation Beds (Non-Distinct Part)	1,843,289		1,843,289		1,843,289	92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	61,793,828		61,793,828		61,793,828	200
201	Less Observation Beds	1,843,289		1,843,289		1,843,289	201
202	Total (line 200 minus line 201)	59,950,539		59,950,539		59,950,539	202

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	32,856,227		32,856,227				30
31	Intensive Care Unit	19,206,948		19,206,948				31
40	Subprovider - IPF	11,591,838		11,591,838				40
43	Nursery	433,116		433,116				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,027,599	3,436,382	8,463,981	0.294330	0.294330	0.294330	50
52	Delivery Room & Labor Room	169,695	302,330	472,025	5.835530	5.835530	5.835530	52
54	Radiology-Diagnostic	3,519,734	6,487,785	10,007,519	0.203322	0.203322	0.203322	54
55.01	CHEMO THERAPY	74,146	215,807	289,953	0.146865	0.146865	0.146865	55.01
56	Radioisotope	825,591	386,791	1,212,382	0.447273	0.447273	0.447273	56
57	CT Scan	5,353,778	16,781,947	22,135,725	0.028580	0.028580	0.028580	57
60	Laboratory	25,783,093	33,255,291	59,038,384	0.085771	0.085771	0.085771	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	11,398,216	1,230,779	12,628,995	0.140593	0.140593	0.140593	65
66	Physical Therapy	641,613	1,012,759	1,654,372	0.511123	0.511123	0.511123	66
69	Electrocardiology	2,593,750	1,695,998	4,289,748	0.089675	0.089675	0.089675	69
71	Medical Supplies Charged to Patients	621,671	338,366	960,037	0.589506	0.589506	0.589506	71
72	Impl. Dev. Charged to Patients	373,512	142,595	516,107	0.801384	0.801384	0.801384	72
73	Drugs Charged to Patients	14,961,879	3,418,174	18,380,053	0.183748	0.183748	0.183748	73
74	Renal Dialysis	3,838,839	225,814	4,064,653	0.226816	0.226816	0.226816	74
76	OP PSYCH		1,249,931	1,249,931	0.292216	0.292216	0.292216	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	6,008,439	9,616,565	15,625,004	0.520061	0.520061	0.520061	91
92	Observation Beds (Non-Distinct Part)		8,056,884	8,056,884	0.228784	0.228784	0.228784	92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	145,279,684	87,854,198	233,133,882				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	145,279,684	87,854,198	233,133,882				202

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	18,097,545		18,097,545		18,097,545	30
31	Intensive Care Unit	3,603,790		3,603,790		3,603,790	31
40	Subprovider - IPF	6,768,775		6,768,775		6,768,775	40
43	Nursery	1,142,899		1,142,899		1,142,899	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,491,206		2,491,206		2,491,206	50
52	Delivery Room & Labor Room	2,754,516		2,754,516		2,754,516	52
54	Radiology-Diagnostic	2,034,744		2,034,744		2,034,744	54
55.01	CHEMO THERAPY	42,584		42,584		42,584	55.01
56	Radioisotope	542,266		542,266		542,266	56
57	CT Scan	632,644		632,644		632,644	57
60	Laboratory	5,063,776		5,063,776		5,063,776	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,775,542		1,775,542		1,775,542	65
66	Physical Therapy	845,587		845,587		845,587	66
69	Electrocardiology	384,685		384,685		384,685	69
71	Medical Supplies Charged to Patients	565,948		565,948		565,948	71
72	Impl. Dev. Charged to Patients	413,600		413,600		413,600	72
73	Drugs Charged to Patients	3,377,302		3,377,302		3,377,302	73
74	Renal Dialysis	921,927		921,927		921,927	74
76	OP PSYCH	365,250		365,250		365,250	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	8,125,953		8,125,953		8,125,953	91
92	Observation Beds (Non-Distinct Part)	1,843,289		1,843,289		1,843,289	92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	61,793,828		61,793,828		61,793,828	200
201	Less Observation Beds	1,843,289		1,843,289		1,843,289	201
202	Total (line 200 minus line 201)	59,950,539		59,950,539		59,950,539	202

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	32,856,227		32,856,227				30
31	Intensive Care Unit	19,206,948		19,206,948				31
40	Subprovider - IPF	11,591,838		11,591,838				40
43	Nursery	433,116		433,116				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,027,599	3,436,382	8,463,981	0.294330	0.294330	0.294330	50
52	Delivery Room & Labor Room	169,695	302,330	472,025	5.835530	5.835530	5.835530	52
54	Radiology-Diagnostic	3,519,734	6,487,785	10,007,519	0.203322	0.203322	0.203322	54
55.01	CHEMO THERAPY	74,146	215,807	289,953	0.146865	0.146865	0.146865	55.01
56	Radioisotope	825,591	386,791	1,212,382	0.447273	0.447273	0.447273	56
57	CT Scan	5,353,778	16,781,947	22,135,725	0.028580	0.028580	0.028580	57
60	Laboratory	25,783,093	33,255,291	59,038,384	0.085771	0.085771	0.085771	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	11,398,216	1,230,779	12,628,995	0.140593	0.140593	0.140593	65
66	Physical Therapy	641,613	1,012,759	1,654,372	0.511123	0.511123	0.511123	66
69	Electrocardiology	2,593,750	1,695,998	4,289,748	0.089675	0.089675	0.089675	69
71	Medical Supplies Charged to Patients	621,671	338,366	960,037	0.589506	0.589506	0.589506	71
72	Impl. Dev. Charged to Patients	373,512	142,595	516,107	0.801384	0.801384	0.801384	72
73	Drugs Charged to Patients	14,961,879	3,418,174	18,380,053	0.183748	0.183748	0.183748	73
74	Renal Dialysis	3,838,839	225,814	4,064,653	0.226816	0.226816	0.226816	74
76	OP PSYCH		1,249,931	1,249,931	0.292216	0.292216	0.292216	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	6,008,439	9,616,565	15,625,004	0.520061	0.520061	0.520061	91
92	Observation Beds (Non-Distinct Part)		8,056,884	8,056,884	0.228784	0.228784	0.228784	92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	145,279,684	87,854,198	233,133,882				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	145,279,684	87,854,198	233,133,882				202

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	2,491,206	260,990	2,230,216		50
52	Delivery Room & Labor Room	2,754,516	46,204	2,708,312		52
54	Radiology-Diagnostic	2,034,744	188,098	1,846,646		54
55.01	CHEMO THERAPY	42,584	287	42,297		55.01
56	Radioisotope	542,266	40,740	501,526		56
57	CT Scan	632,644	29,256	603,388		57
60	Laboratory	5,063,776	87,133	4,976,643		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,775,542	80,957	1,694,585		65
66	Physical Therapy	845,587	73,605	771,982		66
69	Electrocardiology	384,685	2,532	382,153		69
71	Medical Supplies Charged to Patients	565,948	29,481	536,467		71
72	Impl. Dev. Charged to Patients	413,600	21,545	392,055		72
73	Drugs Charged to Patients	3,377,302	48,123	3,329,179		73
74	Renal Dialysis	921,927	176,918	745,009		74
76	OP PSYCH	365,250	41,208	324,042		76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency	8,125,953	197,957	7,927,996		91
92	Observation Beds (Non-Distinct Part)	1,843,289	101,753	1,741,536		92
93.01	CANCER CENTER					93.01
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	32,180,819	1,426,787	30,754,032		200
201	Less Observation Beds	1,843,289	101,753	1,741,536		201
202	Total	30,337,530	1,325,034	29,012,496		202

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		2,491,206	8,463,981	0.294330	50
52	Delivery Room & Labor Room		2,754,516	472,025	5.835530	52
54	Radiology-Diagnostic		2,034,744	10,007,519	0.203322	54
55.01	CHEMO THERAPY		42,584	289,953	0.146865	55.01
56	Radioisotope		542,266	1,212,382	0.447273	56
57	CT Scan		632,644	22,135,725	0.028580	57
60	Laboratory		5,063,776	59,038,384	0.085771	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		1,775,542	12,628,995	0.140593	65
66	Physical Therapy		845,587	1,654,372	0.511123	66
69	Electrocardiology		384,685	4,289,748	0.089675	69
71	Medical Supplies Charged to Patients		565,948	960,037	0.589506	71
72	Impl. Dev. Charged to Patients		413,600	516,107	0.801384	72
73	Drugs Charged to Patients		3,377,302	18,380,053	0.183748	73
74	Renal Dialysis		921,927	4,064,653	0.226816	74
76	OP PSYCH		365,250	1,249,931	0.292216	76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
91	Emergency		8,125,953	15,625,004	0.520061	91
92	Observation Beds (Non-Distinct Part)		1,843,289	8,056,884	0.228784	92
93.01	CANCER CENTER					93.01
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		32,180,819	169,045,753		200
201	Less Observation Beds		1,843,289	8,056,884		201
202	Total		30,337,530	160,988,869		202

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V [XX] PPS
Applicable [XX] Title XVIII, Part A [] TEFRA
Boxes: [] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	999,021		999,021	20,294	49.23	3,732	183,726	30
31	Intensive Care Unit	109,469		109,469	2,059	53.17	572	30,413	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	729,171		729,171	8,373	87.09	1,714	149,272	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	42,927		42,927	71	604.61			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,880,588		1,880,588	30,797		6,018	363,411	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0177

WORKSHEET D PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF
 Boxes: ☐ Title XIX ☐ IRF ☐ TEFRA

		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 (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	260,990	8,463,981	0.030835	1,027,824	31,693	50
52	Delivery Room & Labor Room	46,204	472,025	0.097885			52
54	Radiology-Diagnostic	188,098	10,007,519	0.018796	1,374,888	25,842	54
55.01	CHEMO THERAPY	287	289,953	0.000990	5,582	6	55.01
56	Radioisotope	40,740	1,212,382	0.033603	310,270	10,426	56
57	CT Scan	29,256	22,135,725	0.001322	2,570,546	3,398	57
60	Laboratory	87,133	59,038,384	0.001476	8,763,069	12,934	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	80,957	12,628,995	0.006410	2,951,613	18,920	65
66	Physical Therapy	73,605	1,654,372	0.044491	209,604	9,325	66
69	Electrocardiology	2,532	4,289,748	0.000590	776,874	458	69
71	Medical Supplies Charged to Pat	29,481	960,037	0.030708	117,707	3,615	71
72	Impl. Dev. Charged to Patients	21,545	516,107	0.041745	74,483	3,109	72
73	Drugs Charged to Patients	48,123	18,380,053	0.002618	3,790,561	9,924	73
74	Renal Dialysis	176,918	4,064,653	0.043526	967,775	42,123	74
76	OP PSYCH	41,208	1,249,931	0.032968			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	197,957	15,625,004	0.012669	1,162,957	14,734	91
92	Observation Beds (Non-Distinct	101,753	8,056,884	0.012629			92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,426,787	169,045,753		24,103,753	186,507	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D PART III

Check ☐ Title V
Applicable ☒ Title XVIII, Part A
Boxes: ☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ PPS
☐ TEFRA
☐ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	20,294		3,732		30
31	Intensive Care Unit	2,059		572		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	8,373		1,714		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	71				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	30,797		6,018		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0177

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
55.01	CHEMO THERAPY									55.01
56	Radioisotope									56
57	CT Scan									57
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	OP PSYCH									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.01	CANCER CENTER									93.01
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0177

WORKSHEET D PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	8,463,981			1,027,824		386,492		50
52	Delivery Room & Labor Room	472,025							52
54	Radiology-Diagnostic	10,007,519			1,374,888		494,363		54
55.01	CHEMO THERAPY	289,953			5,582		70,267		55.01
56	Radioisotope	1,212,382			310,270		80,187		56
57	CT Scan	22,135,725			2,570,546		1,338,941		57
60	Laboratory	59,038,384			8,763,069		1,612,788		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	12,628,995			2,951,613		84,630		65
66	Physical Therapy	1,654,372			209,604		6,123		66
69	Electrocardiology	4,289,748			776,874		258,937		69
71	Medical Supplies Charged to Pat	960,037			117,707		37,267		71
72	Impl. Dev. Charged to Patients	516,107			74,483		18,560		72
73	Drugs Charged to Patients	18,380,053			3,790,561		197,785		73
74	Renal Dialysis	4,064,653			967,775		55,301		74
76	OP PSYCH	1,249,931					288,810		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	15,625,004			1,162,957		717,992		91
92	Observation Beds (Non-Distinct	8,056,884					694,390		92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	169,045,753			24,103,753		6,342,833		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0177

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.294330	386,492			113,756			50
52	Delivery Room & Labor Room	5.835530							52
54	Radiology-Diagnostic	0.203322	494,363			100,515			54
55.01	CHEMO THERAPY	0.146865	70,267			10,320			55.01
56	Radioisotope	0.447273	80,187			35,865			56
57	CT Scan	0.028580	1,338,941			38,267			57
60	Laboratory	0.085771	1,612,788		308	138,330		26	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.140593	84,630			11,898			65
66	Physical Therapy	0.511123	6,123			3,130			66
69	Electrocardiology	0.089675	258,937			23,220			69
71	Medical Supplies Charged to Pat	0.589506	37,267			21,969			71
72	Impl. Dev. Charged to Patients	0.801384	18,560			14,874			72
73	Drugs Charged to Patients	0.183748	197,785			36,343			73
74	Renal Dialysis	0.226816	55,301			12,543			74
76	OP PSYCH	0.292216	288,810			84,395			76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.520061	717,992			373,400			91
92	Observation Beds (Non-Distinct	0.228784	694,390			158,865			92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		6,342,833		308	1,177,690		26	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		6,342,833		308	1,177,690		26	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S177

WORKSHEET D
PART II

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☒ PPS
Applicable ☒ Title XVIII, Part A ☒ IPF
Boxes: ☐ Title XIX ☐ IRF ☐ TEFRA

		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 (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	260,990	8,463,981	0.030835			50
52	Delivery Room & Labor Room	46,204	472,025	0.097885			52
54	Radiology-Diagnostic	188,098	10,007,519	0.018796			54
55.01	CHEMO THERAPY	287	289,953	0.000990			55.01
56	Radioisotope	40,740	1,212,382	0.033603			56
57	CT Scan	29,256	22,135,725	0.001322			57
60	Laboratory	87,133	59,038,384	0.001476			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	80,957	12,628,995	0.006410			65
66	Physical Therapy	73,605	1,654,372	0.044491			66
69	Electrocardiology	2,532	4,289,748	0.000590			69
71	Medical Supplies Charged to Pat	29,481	960,037	0.030708			71
72	Impl. Dev. Charged to Patients	21,545	516,107	0.041745			72
73	Drugs Charged to Patients	48,123	18,380,053	0.002618			73
74	Renal Dialysis	176,918	4,064,653	0.043526			74
76	OP PSYCH	41,208	1,249,931	0.032968			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	197,957	15,625,004	0.012669			91
92	Observation Beds (Non-Distinct		8,056,884				92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,325,034	169,045,753				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S177

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☒ Title XVIII, Part A
☐ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
55.01	CHEMO THERAPY									55.01
56	Radioisotope									56
57	CT Scan									57
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	OP PSYCH									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.01	CANCER CENTER									93.01
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S177

WORKSHEET D PART IV

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ PPS
 Applicable ☒ Title XVIII, Part A ☒ IPF ☐ SNF ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	8,463,981							50
52	Delivery Room & Labor Room	472,025							52
54	Radiology-Diagnostic	10,007,519							54
55.01	CHEMO THERAPY	289,953							55.01
56	Radioisotope	1,212,382							56
57	CT Scan	22,135,725							57
60	Laboratory	59,038,384							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	12,628,995							65
66	Physical Therapy	1,654,372							66
69	Electrocardiology	4,289,748							69
71	Medical Supplies Charged to Pat	960,037							71
72	Impl. Dev. Charged to Patients	516,107							72
73	Drugs Charged to Patients	18,380,053							73
74	Renal Dialysis	4,064,653							74
76	OP PSYCH	1,249,931							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	15,625,004							91
92	Observation Beds (Non-Distinct	8,056,884							92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	169,045,753							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S177

WORKSHEET D
PART V

Check
Applicable
Boxes:

☐ Title V - O/P

☒ Title XVIII, Part B

☐ Title XIX - O/P

☐ Hospital

☒ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ Swing Bed SNF

☐ Swing Bed NF

☐ ICF/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.294330							50
52	Delivery Room & Labor Room	5.835530							52
54	Radiology-Diagnostic	0.203322							54
55.01	CHEMO THERAPY	0.146865							55.01
56	Radioisotope	0.447273							56
57	CT Scan	0.028580							57
60	Laboratory	0.085771							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.140593							65
66	Physical Therapy	0.511123							66
69	Electrocardiology	0.089675							69
71	Medical Supplies Charged to Pat	0.589506							71
72	Impl. Dev. Charged to Patients	0.801384							72
73	Drugs Charged to Patients	0.183748							73
74	Renal Dialysis	0.226816							74
76	OP PSYCH	0.292216							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.520061							91
92	Observation Beds (Non-Distinct	0.228784							92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check [] Title V
Applicable [] Title XVIII, Part A
Boxes: [XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	999,021		999,021	20,294	49.23	976	48,048	30
31	Intensive Care Unit	109,469		109,469	2,059	53.17	151	8,029	31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	729,171		729,171	8,373	87.09	448	39,016	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	42,927		42,927	71	604.61	69	41,718	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,880,588		1,880,588	30,797		1,644	136,811	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-0177****WORKSHEET D
PART II**

Check ☐ Title V ☒ Hospital ☐ SUB (Other)
Applicable ☐ Title XVIII, Part A ☐ IPF
Boxes: ☒ Title XIX ☐ IRF

		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 (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	260,990	8,463,981	0.030835			50
52	Delivery Room & Labor Room	46,204	472,025	0.097885			52
54	Radiology-Diagnostic	188,098	10,007,519	0.018796			54
55.01	CHEMO THERAPY	287	289,953	0.000990			55.01
56	Radioisotope	40,740	1,212,382	0.033603			56
57	CT Scan	29,256	22,135,725	0.001322			57
60	Laboratory	87,133	59,038,384	0.001476			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	80,957	12,628,995	0.006410			65
66	Physical Therapy	73,605	1,654,372	0.044491			66
69	Electrocardiology	2,532	4,289,748	0.000590			69
71	Medical Supplies Charged to Pat	29,481	960,037	0.030708			71
72	Impl. Dev. Charged to Patients	21,545	516,107	0.041745			72
73	Drugs Charged to Patients	48,123	18,380,053	0.002618			73
74	Renal Dialysis	176,918	4,064,653	0.043526			74
76	OP PSYCH	41,208	1,249,931	0.032968			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	197,957	15,625,004	0.012669			91
92	Observation Beds (Non-Distinct	101,753	8,056,884	0.012629			92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,426,787	169,045,753				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**WORKSHEET D
PART III**

Check ☐ Title V ☐ PPS
Applicable ☐ Title XVIII, Part A ☐ TEFRA
Boxes: ☒ Title XIX ☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	20,294		976		30
31	Intensive Care Unit	2,059		151		31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	8,373		448		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	71		69		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	30,797		1,644		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0177

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
55.01	CHEMO THERAPY									55.01
56	Radioisotope									56
57	CT Scan									57
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	OP PSYCH									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.01	CANCER CENTER									93.01
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0177

WORKSHEET D PART IV

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	8,463,981							50
52	Delivery Room & Labor Room	472,025							52
54	Radiology-Diagnostic	10,007,519							54
55.01	CHEMO THERAPY	289,953							55.01
56	Radioisotope	1,212,382							56
57	CT Scan	22,135,725							57
60	Laboratory	59,038,384							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	12,628,995							65
66	Physical Therapy	1,654,372							66
69	Electrocardiology	4,289,748							69
71	Medical Supplies Charged to Pat	960,037							71
72	Impl. Dev. Charged to Patients	516,107							72
73	Drugs Charged to Patients	18,380,053							73
74	Renal Dialysis	4,064,653							74
76	OP PSYCH	1,249,931							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	15,625,004							91
92	Observation Beds (Non-Distinct	8,056,884							92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	169,045,753							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0177

WORKSHEET D PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.294330							50
52	Delivery Room & Labor Room	5.835530							52
54	Radiology-Diagnostic	0.203322							54
55.01	CHEMO THERAPY	0.146865							55.01
56	Radioisotope	0.447273							56
57	CT Scan	0.028580							57
60	Laboratory	0.085771							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.140593							65
66	Physical Therapy	0.511123							66
69	Electrocardiology	0.089675							69
71	Medical Supplies Charged to Pat	0.589506							71
72	Impl. Dev. Charged to Patients	0.801384							72
73	Drugs Charged to Patients	0.183748							73
74	Renal Dialysis	0.226816							74
76	OP PSYCH	0.292216							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.520061							91
92	Observation Beds (Non-Distinct	0.228784							92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-S177****WORKSHEET D
PART II**

Check ☐ Title V ☐ Hospital ☐ SUB (Other)
Applicable ☐ Title XVIII, Part A ☒ IPF
Boxes: ☒ Title XIX ☐ IRF

		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 (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	260,990	8,463,981	0.030835			50
52	Delivery Room & Labor Room	46,204	472,025	0.097885			52
54	Radiology-Diagnostic	188,098	10,007,519	0.018796			54
55.01	CHEMO THERAPY	287	289,953	0.000990			55.01
56	Radioisotope	40,740	1,212,382	0.033603			56
57	CT Scan	29,256	22,135,725	0.001322			57
60	Laboratory	87,133	59,038,384	0.001476			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	80,957	12,628,995	0.006410			65
66	Physical Therapy	73,605	1,654,372	0.044491			66
69	Electrocardiology	2,532	4,289,748	0.000590			69
71	Medical Supplies Charged to Pat	29,481	960,037	0.030708			71
72	Impl. Dev. Charged to Patients	21,545	516,107	0.041745			72
73	Drugs Charged to Patients	48,123	18,380,053	0.002618			73
74	Renal Dialysis	176,918	4,064,653	0.043526			74
76	OP PSYCH	41,208	1,249,931	0.032968			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	197,957	15,625,004	0.012669			91
92	Observation Beds (Non-Distinct		8,056,884				92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	1,325,034	169,045,753				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S177

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ Hospital
☒ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
54	Radiology-Diagnostic									54
55.01	CHEMO THERAPY									55.01
56	Radioisotope									56
57	CT Scan									57
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
74	Renal Dialysis									74
76	OP PSYCH									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.01	CANCER CENTER									93.01
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S177

WORKSHEET D PART IV

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☒ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	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)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	8,463,981							50
52	Delivery Room & Labor Room	472,025							52
54	Radiology-Diagnostic	10,007,519							54
55.01	CHEMO THERAPY	289,953							55.01
56	Radioisotope	1,212,382							56
57	CT Scan	22,135,725							57
60	Laboratory	59,038,384							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	12,628,995							65
66	Physical Therapy	1,654,372							66
69	Electrocardiology	4,289,748							69
71	Medical Supplies Charged to Pat	960,037							71
72	Impl. Dev. Charged to Patients	516,107							72
73	Drugs Charged to Patients	18,380,053							73
74	Renal Dialysis	4,064,653							74
76	OP PSYCH	1,249,931							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	15,625,004							91
92	Observation Beds (Non-Distinct	8,056,884							92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	169,045,753							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S177

WORKSHEET D PART V

Check [] Title V - O/P [] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [] Title XVIII, Part B [XX] IPF [] SNF [] Swing Bed NF
Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/IID

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room	0.294330							50
52	Delivery Room & Labor Room	5.835530							52
54	Radiology-Diagnostic	0.203322							54
55.01	CHEMO THERAPY	0.146865							55.01
56	Radioisotope	0.447273							56
57	CT Scan	0.028580							57
60	Laboratory	0.085771							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.140593							65
66	Physical Therapy	0.511123							66
69	Electrocardiology	0.089675							69
71	Medical Supplies Charged to Pat	0.589506							71
72	Impl. Dev. Charged to Patients	0.801384							72
73	Drugs Charged to Patients	0.183748							73
74	Renal Dialysis	0.226816							74
76	OP PSYCH	0.292216							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
91	Emergency	0.520061							91
92	Observation Beds (Non-Distinct	0.228784							92
93.01	CANCER CENTER								93.01
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0177****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **Title XIX - I/P** ☐ **IRF** ☐ **NF** ☐ **Other**

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,294	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,294	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	18,227	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,732	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	18,097,545	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18,097,545	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	18,097,545	37

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0177****WORKSHEET D-1
PART II**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **IPF** ☐ **TEFRA**
Boxes: ☐ **Title XIX - I/P** ☐ **IRF** ☐ **Other**

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						891.77 38
39	Program general inpatient routine service cost (line 9 x line 38)						3,328,086 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						3,328,086 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	3,603,790	2,059	1,750.26	572	1,001,149	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						3,788,419 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						8,117,654 49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						214,139 50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						186,507 51
52	Total Program excludable cost (sum of lines 50 and 51)						400,646 52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						7,717,008 53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0177

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,067	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					891.77	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,843,289	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	999,021	18,097,545	0.055202	1,843,289	101,753	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-S177****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☒ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☐ **Title XIX - I/P** ☐ **IRF** ☐ **NF** ☐ **Other**

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,373	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,373	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	8,373	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,714	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	6,768,775	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,768,775	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,768,775	37

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-S177****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☒ PPS
 Applicable ☒ Title XVIII, Part A ☒ IPF ☐ TEFRA
 Boxes: ☐ Title XIX - I/P ☐ IRF ☐ Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	808.40	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,385,598	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,385,598	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,385,598	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	149,272	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	149,272	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	1,236,326	53
TARGET AMOUNT AND LIMIT COMPUTATION			
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
PROGRAM INPATIENT ROUTINE SWING BED COST			
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0177****WORKSHEET D-1
PART I**

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☐ **PPS**
Applicable ☐ **Title XVIII, Part A** ☐ **IPF** ☐ **SNF** ☐ **TEFRA**
Boxes: ☒ **Title XIX - I/P** ☐ **IRF** ☐ **NF** ☒ **Other**

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	20,294	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	20,294	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	18,227	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	976	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	71	15
16	Nursery days (title V or XIX only)	69	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	18,097,545	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	18,097,545	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	18,097,545	37

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-0177****WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ TEFRA
 Boxes: ☒ Title XIX - I/P ☐ IRF ☒ Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						891.77 38
39	Program general inpatient routine service cost (line 9 x line 38)						870,368 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					870,368	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)	1,142,899	71	16,097.17	69	1,110,705	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit	3,603,790	2,059	1,750.26	151	264,289	43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,245,362	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					97,795	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					97,795	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0177

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,067	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S177

**WORKSHEET D-1
PART I**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☒ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX - I/P ☐ IRF ☐ NF ☒ Other

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,373	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,373	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	8,373	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	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)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	448	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	6,768,775	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6,768,775	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	6,768,775	37

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S177

**WORKSHEET D-1
PART II**

Check ☐ Title V - I/P ☐ Hospital ☐ SUB (Other) ☐ PPS
Applicable ☐ Title XVIII, Part A ☒ IPF ☐ TEFRA
Boxes: ☒ Title XIX - I/P ☐ IRF ☒ Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS			1
38	Adjusted general inpatient routine service cost per diem (see instructions)	808.40	38
39	Program general inpatient routine service cost (line 9 x line 38)	362,163	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	362,163	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	362,163	49
PASS THROUGH COST ADJUSTMENTS			
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	39,016	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	39,016	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53
TARGET AMOUNT AND LIMIT COMPUTATION			
54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	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 (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63
PROGRAM INPATIENT ROUTINE SWING BED COST			
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0177

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☒ PPS
 Applicable ☒ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☐ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		12,605,034		30
31	Intensive Care Unit		1,972,542		31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.294330	1,027,824	302,519	50
52	Delivery Room & Labor Room	5.835530			52
54	Radiology-Diagnostic	0.203322	1,374,888	279,545	54
55.01	CHEMO THERAPY	0.146865	5,582	820	55.01
56	Radioisotope	0.447273	310,270	138,775	56
57	CT Scan	0.028580	2,570,546	73,466	57
60	Laboratory	0.085771	8,763,069	751,617	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.140593	2,951,613	414,976	65
66	Physical Therapy	0.511123	209,604	107,133	66
69	Electrocardiology	0.089675	776,874	69,666	69
71	Medical Supplies Charged to Patients	0.589506	117,707	69,389	71
72	Impl. Dev. Charged to Patients	0.801384	74,483	59,689	72
73	Drugs Charged to Patients	0.183748	3,790,561	696,508	73
74	Renal Dialysis	0.226816	967,775	219,507	74
76	OP PSYCH	0.292216			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.520061	1,162,957	604,809	91
92	Observation Beds (Non-Distinct Part)	0.228784			92
93.01	CANCER CENTER				93.01
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		24,103,753	3,788,419	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		24,103,753		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S177

WORKSHEET D-3

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☒ PPS
 Applicable ☒ Title XVIII, Part A ☒ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☐ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.294330			50
52	Delivery Room & Labor Room	5.835530			52
54	Radiology-Diagnostic	0.203322			54
55.01	CHEMO THERAPY	0.146865			55.01
56	Radioisotope	0.447273			56
57	CT Scan	0.028580			57
60	Laboratory	0.085771			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.140593			65
66	Physical Therapy	0.511123			66
69	Electrocardiology	0.089675			69
71	Medical Supplies Charged to Patients	0.589506			71
72	Impl. Dev. Charged to Patients	0.801384			72
73	Drugs Charged to Patients	0.183748			73
74	Renal Dialysis	0.226816			74
76	OP PSYCH	0.292216			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.520061			91
92	Observation Beds (Non-Distinct Part)	0.228784			92
93.01	CANCER CENTER				93.01
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0177

WORKSHEET D-3

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.294330			50
52	Delivery Room & Labor Room	5.835530			52
54	Radiology-Diagnostic	0.203322			54
55.01	CHEMO THERAPY	0.146865			55.01
56	Radioisotope	0.447273			56
57	CT Scan	0.028580			57
60	Laboratory	0.085771			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.140593			65
66	Physical Therapy	0.511123			66
69	Electrocardiology	0.089675			69
71	Medical Supplies Charged to Patients	0.589506			71
72	Impl. Dev. Charged to Patients	0.801384			72
73	Drugs Charged to Patients	0.183748			73
74	Renal Dialysis	0.226816			74
76	OP PSYCH	0.292216			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.520061			91
92	Observation Beds (Non-Distinct Part)	0.228784			92
93.01	CANCER CENTER				93.01
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S177

WORKSHEET D-3

Check ☐ Title V ☐ Hospital ☐ SUB (Other) ☐ Swing Bed SNF ☐ PPS
 Applicable ☐ Title XVIII, Part A ☒ IPF ☐ SNF ☐ Swing Bed NF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☐ ICF/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.294330			50
52	Delivery Room & Labor Room	5.835530			52
54	Radiology-Diagnostic	0.203322			54
55.01	CHEMO THERAPY	0.146865			55.01
56	Radioisotope	0.447273			56
57	CT Scan	0.028580			57
60	Laboratory	0.085771			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.140593			65
66	Physical Therapy	0.511123			66
69	Electrocardiology	0.089675			69
71	Medical Supplies Charged to Patients	0.589506			71
72	Impl. Dev. Charged to Patients	0.801384			72
73	Drugs Charged to Patients	0.183748			73
74	Renal Dialysis	0.226816			74
76	OP PSYCH	0.292216			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
91	Emergency	0.520061			91
92	Observation Beds (Non-Distinct Part)	0.228784			92
93.01	CANCER CENTER				93.01
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	3,662,219			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	4,055,402			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	112,698			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	1,128,311			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	109.06			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	11.29			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 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.				7.01
8	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).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)				8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	11.29			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	20.00			10
11	FTE count for residents in dental and podiatric programs				11
12	Current year allowable FTE (see instructions)	11.29			12
13	Total allowable FTE count for the prior year	11.29			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	11.29			14
15	Sum of lines 12 through 14 divided by 3	11.29			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	11.29			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.103521			19
20	Prior year resident to bed ratio (see instructions)	0.058241			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.058241			21
22	IME payment adjustment (see instructions)	241,623			22
22.01	IME payment adjustment - Managed Care (see instructions)	35,325			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	8.71			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	241,623			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	35,325			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.1848			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.7931			31
32	Sum of lines 30 and 31	0.9779			32
33	Allowable disproportionate share percentage (see instructions)	0.5083			33
34	Disproportionate share adjustment (see instructions)	980,717			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000464469	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	3,405,680		3,142,920	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,707,506		1,567,154	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,274,660			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E
PART A****PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
47	Subtotal (see instructions)	12,327,319			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	12,362,644			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	804,244			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	282,517			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies				54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	13,449,405			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	13,449,405			61
62	Deductibles billed to program beneficiaries	959,952			62
63	Coinsurance billed to program beneficiaries	105,210			63
64	Allowable bad debts (see instructions)	737,860			64
65	Adjusted reimbursable bad debts (see instructions)	479,609			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	508,001			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	12,863,852			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (specify) (see instructions)				70
70.93	HVBP payment adjustment amount (see instructions)	19,540			70.93
70.94	HRR adjustment amount (see instructions)	-44,604			70.94
71	Amount due provider (see instructions)	12,838,788			71
71.01	Sequestration adjustment (see instructions)	256,776			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	11,618,059			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	963,953			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	321,053			75
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
HSP Bonus Payment Amount		Prior to 10/1	On or After 10/1		
100	HSP bonus amount (see instructions)				100
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
HRR Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-0177****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	26			1
2	Medical and other services reimbursed under OPPS (see instructions)	1,177,690			2
3	OPPS payments	775,354			3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.800			5
6	Line 2 times line 5	942,152			6
7	Sum of lines 3, 4, and 4.01, divided by line 6	0.8230			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	26			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	308			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	308			14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	308			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	282			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	26			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	775,354			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	167,260			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	608,120			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	35,012			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	643,132			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	643,132			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	98,064			34
35	Adjusted reimbursable bad debts (see instructions)	63,742			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	42,556			36
37	Subtotal (see instructions)	706,874			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	706,874			40
40.01	Sequestration adjustment (see instructions)	14,137			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	747,895			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-55,158			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-S177****WORKSHEET E
PART B**Check applicable box: ☐ Hospital ☒ IPF ☐ IRF ☐ SUB (Other) ☐ SNF**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-0177****WORKSHEET E-1
PART I**

Check ☒ Hospital ☐ SUB (Other)
Applicable ☐ IPF ☐ SNF
Boxes: ☐ IRF ☐ Swing Bed SNF

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			11,693,714		787,632
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51	10/26/2017	75,655	10/26/2017
		Provider	.52			39,737
		to	.53			3.51
		Program	.54			3.52
			.55			3.53
			.56			3.54
			.57			3.55
			.58			3.56
			.59			3.57
			.99			3.58
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			-75,655		-39,737
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			11,618,059		747,895
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.11
			.51			5.12
		Provider	.52			5.13
		to	.53			5.14
		Program	.54			5.15
			.55			5.16
			.56			5.17
			.57			5.18
			.58			5.19
			.59			5.20
			.99			5.21
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.22
6	Determined net settlement amount (balance due)		.01	963,953		6.01
	based on the cost report (1)		.02			-55,158
7	Total Medicare program liability (see instructions)			12,582,012		692,737
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-S177****WORKSHEET E-3
PART II**

Check ☐ Hospital
Applicable ☒ Subprovider IPF
Box:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)		1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)		4
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)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	22.939726	9
10	Teaching adjustment factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)		16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)		18
19	Deductibles		19
20	Subtotal (line 18 minus line 19)		20
21	Coinurance		21
22	Subtotal (line 20 minus line 21)		22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)		23
24	Adjusted reimbursable bad debts (see instructions)		24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)		25
26	Subtotal (sum of lines 22 and 24)		26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)		31
31.01	Sequestration adjustment (see instructions)		31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments		32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0177

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☐ PPS
 Applicable ☒ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	2,245,362		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	2,245,362		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	2,245,362		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,245,362		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	2,245,362		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S177

WORKSHEET E-3
PART VII

Check ☐ Title V ☐ Hospital ☐ NF ☐ PPS
 Applicable ☒ Title XIX ☒ Subprovider IPF ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	362,163		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	362,163		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	362,163		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	362,163		18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	362,163		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

Check [] Title V
Applicable [XX] Title XVIII
Box: [] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996		11.29	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)		11.29	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)		20.00	6
7	Enter the lesser of line 5 or line 6		11.29	7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	20.00	0.00	20.00
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	11.29	0.00	11.29
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	11.29	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	11.29	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	11.29	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	11.29	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	11.29	0.00	
18	Per resident amount	119,561.21	113,335.31	
19	Approved amount for resident costs	1,349,846		1,349,846
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			8.71
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			1,349,846
COMPUTATION OF PROGRAM PATIENT LOAD				
26	Inpatient days (see instructions)	6,018	847	
27	Total inpatient days (see instructions)	28,675	28,675	
28	Ratio of inpatient days to total inpatient days	0.209869	0.029538	
29	Program direct GME amount	283,291	39,872	
30	Reduction for direct GME payments for Medicare Advantage		5,634	
31	Net Program direct GME amount			317,529
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			4,064,653
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
Part A Reasonable Cost				
37	Reasonable cost (see instructions)			9,503,252
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			9,503,252
Part B Reasonable Cost				
42	Reasonable cost (see instructions)			1,177,716
43	Primary payer payments (see instructions)			
44	Total Part B reasonable cost (line 42 minus line 43)			1,177,716
45	Total reasonable cost (sum of lines 41 and 44)			10,680,968
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.889737
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.110263
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	Total program GME payment (line 31)			317,529
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			282,517
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			35,012

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DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**WORKSHEET E-4**

Check ☐ Title V
Applicable ☐ Title XVIII
Box: ☒ Title XIX

	COMPUTATION OF TOTAL DIRECT GME AMOUNT			
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care 1	Other 2	Total 3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00 8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00 9
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
	COMPUTATION OF PROGRAM PATIENT LOAD	Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	1,590	14,499	
27	Total inpatient days (see instructions)	28,675	28,675	
28	Ratio of inpatient days to total inpatient days	0.055449	0.505632	
29	Program direct GME amount			
30	Reduction for direct GME payments for Medicare Advantage			
31	Net Program direct GME amount			
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			
35	Medicare outpatient ESRD charges (see instructions)			
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	Part A Reasonable Cost			
37	Reasonable cost (see instructions)			
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			
39	Cost of physicians' services in a teaching hospital (see instructions)			
40	Primary payer payments (see instructions)			
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			
	Part B Reasonable Cost			
42	Reasonable cost (see instructions)			
43	Primary payer payments (see instructions)			
44	Total Part B reasonable cost (line 42 minus line 43)			
45	Total reasonable cost (sum of lines 41 and 44)			
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	Total program GME payment (line 31)			
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			

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BALANCE SHEET**WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	8,433,950				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	126,083,973				4
5	Other receivables	5,444,687				5
6	Allowances for uncollectible notes and accounts receivable	-75,212,442				6
7	Inventory	998,058				7
8	Prepaid expenses	1,651,420				8
9	Other current assets	57,853,055				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	125,252,701				11
	FIXED ASSETS					
12	Land	2,482,024				12
13	Land improvements	217,663				13
14	Accumulated depreciation	-8,182				14
15	Buildings	53,949,474				15
16	Accumulated depreciation	-39,581,854				16
17	Leasehold improvements	2,260				17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks	171,770				21
22	Accumulated depreciation	-175,615				22
23	Major movable equipment	33,042,412				23
24	Accumulated depreciation	-27,764,306				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	22,335,646				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	490,534				34
35	Total other assets (sum of lines 31-34)	490,534				35
36	Total assets (sum of lines 11, 30 and 35)	148,078,881				36
	Liabilities and Fund Balances					
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	5,683,094				37
38	Salaries, wages and fees payable	5,800,477				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	6,913,429				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	112,365				44
45	Total current liabilities (sum of lines 37 thru 44)	18,509,365				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	8,233,346				47
48	Unsecured loans					48
49	Other long term liabilities	1,337,428				49
50	Total long term liabilities (sum of lines 46 thru 49)	9,570,774				50
51	Total liabilities (sum of lines 45 and 50)	28,080,139				51
	CAPITAL ACCOUNTS					
52	General fund balance	119,998,742				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	119,998,742				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	148,078,881				60

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STATEMENT OF CHANGES IN FUND BALANCES**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		121,053,229		1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,054,488		2
3	Total (sum of line 1 and line 2)		119,998,741		3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		119,998,741		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		119,998,741		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	44,448,065		44,448,065	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	44,448,065		44,448,065	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	19,200,463		19,200,463	11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	19,200,463		19,200,463	16
17	Total inpatient routine care services (sum of lines 10 and 16)	63,648,528		63,648,528	17
18	Ancillary services	81,550,103		81,550,103	18
19	Outpatient services		88,229,871	88,229,871	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	145,198,631	88,229,871	233,428,502	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		84,396,401	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		84,396,401	43

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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	233,428,502	1
2	Less contractual allowances and discounts on patients' accounts	156,137,057	2
3	Net patient revenues (line 1 minus line 2)	77,291,445	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	84,396,401	4
5	Net income from service to patients (line 3 minus line 4)	-7,104,956	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	2,242,009	6
7	Income from investments	121,272	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	264,992	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	6,203	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	53	21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (DIALYSIS RENT)	216,275	24
24.01	Other (DOCTOR OFFICE RENTALS)	178,532	24.01
24.02	Other (MEDICAL SCHOOL BILLING)	1,894,639	24.02
24.03	Other (RADIOLOGY PHYSICIAN REV)	584,903	24.03
24.04	Other (RENTAL OF QUARTERS)	219,750	24.04
24.05	Other (MISC INCOME)	200,530	24.05
24.06	Other (GALA REVENUE)	121,310	24.06
25	Total other income (sum of lines 6-24)	6,050,468	25
26	Total (line 5 plus line 25)	-1,054,488	26
29	Net income (or loss) for the period (line 26 minus line 28)	-1,054,488	29

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CALCULATION OF CAPITAL PAYMENT**COMPONENT CCN: 14-0177****WORKSHEET L**

Check ☐ **Title V** ☒ **Hospital** ☒ **PPS**
Applicable ☒ **Title XVIII, Part A** ☐ **SUB (Other)** ☐ **Cost Method**
Boxes: ☐ **Title XIX**

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier	626,710	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	3,309	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	55.62	3
4	Number of interns & residents (see instructions)	11.29	4
5	Indirect medical education percentage (see instructions)	5.90	5
6	Indirect medical education adjustment (see instructions)	36,976	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.1848	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.7931	8
9	Sum of lines 7 and 8	0.9779	9
10	Allowable disproportionate share percentage (see instructions)	0.2190	10
11	Disproportionate share adjustment (see instructions)	137,249	11
12	Total prospective capital payments (see instructions)	804,244	12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	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)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1 PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
31	Intensive Care Unit							31
40	Subprovider - IPF							40
43	Nursery							43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
54	Radiology-Diagnostic							54
55.01	CHEMO THERAPY							55.01
56	Radioisotope							56
57	CT Scan							57
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
74	Renal Dialysis							74
76	OP PSYCH							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
194	OTHER NON REIMBURSEABLE COST CENTER							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

		TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
	COST CENTERS	PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	Adults & Pediatrics	18.39		4.81				23.20	30
31	Intensive Care Unit	27.78		7.33				35.11	31
43	Nursery			97.18				97.18	43
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	12.14	4.57					16.71	50
54	Radiology-Diagnostic	13.74	4.94					18.68	54
55.01	CHEMO THERAPY	1.93	24.23					26.16	55.01
56	Radioisotope	25.59	6.61					32.20	56
57	CT Scan	11.61	6.05					17.66	57
60	Laboratory	14.84	2.73					17.57	60
65	Respiratory Therapy	23.37	0.67					24.04	65
66	Physical Therapy	12.67	0.37					13.04	66
69	Electrocardiology	18.11	6.04					24.15	69
71	Medical Supplies Charged to Pat	12.26	3.88					16.14	71
72	Impl. Dev. Charged to Patients	14.43	3.60					18.03	72
73	Drugs Charged to Patients	20.62	1.08					21.70	73
74	Renal Dialysis	23.81	1.36					25.17	74
76	OP PSYCH		23.11					23.11	76
91	Emergency	7.44	4.60					12.04	91
92	Observation Beds (Non-Distinct		8.62					8.62	92
200	TOTAL CHARGES	14.26	3.75					18.01	200

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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,960,993	5.60	-3,960,993	-11.81			1
2	Cap Rel Costs-Mvble Equip							2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	7,386,820	10.44	-7,386,820	-22.02			4
5	Administrative & General	11,594,798	16.39	-11,594,798	-34.56			5
6	Maintenance & Repairs	841,771	1.19	-841,771	-2.51			6
7	Operation of Plant	2,330,581	3.30	-2,330,581	-6.95			7
8	Laundry & Linen Service	355,422	0.50	-355,422	-1.06			8
9	Housekeeping	1,265,704	1.79	-1,265,704	-3.77			9
10	Dietary	1,018,932	1.44	-1,018,932	-3.04			10
11	Cafeteria	420,455	0.59	-420,455	-1.25			11
12	Maintenance of Personnel							12
13	Nursing Administration	1,528,817	2.16	-1,528,817	-4.56			13
14	Central Services & Supply	136,935	0.19	-136,935	-0.41			14
15	Pharmacy	703,515	0.99	-703,515	-2.10			15
16	Medical Records & Library	835,919	1.18	-835,919	-2.49			16
17	Social Service	150,192	0.21	-150,192	-0.45			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	941,513	1.33	-941,513	-2.81			21
22	I&R Services-Other Prgm Costs Apprvd	77,452	0.11	-77,452	-0.23			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	9,119,288	12.89	10,228,745	30.49	19,348,033	27.36	30
31	Intensive Care Unit	2,152,172	3.04	1,504,428	4.48	3,656,600	5.17	31
40	Subprovider - IPF	1,984,024	2.81	4,784,751	14.26	6,768,775	9.57	40
43	Nursery	646,538	0.91	550,576	1.64	1,197,114	1.69	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,111,219	1.57	1,487,012	4.43	2,598,231	3.67	50
52	Delivery Room & Labor Room	1,715,863	2.43	1,038,653	3.10	2,754,516	3.89	52
54	Radiology-Diagnostic	1,014,772	1.43	1,036,872	3.09	2,051,644	2.90	54
55.01	CHEMO THERAPY	28,234	0.04	14,350	0.04	42,584	0.06	55.01
56	Radioisotope	309,258	0.44	233,008	0.69	542,266	0.77	56
57	CT Scan	400,079	0.57	232,565	0.69	632,644	0.89	57
60	Laboratory	3,959,538	5.60	1,104,238	3.29	5,063,776	7.16	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,093,703	1.55	757,176	2.26	1,850,879	2.62	65
66	Physical Therapy	460,771	0.65	384,816	1.15	845,587	1.20	66
69	Electrocardiology	251,150	0.36	133,535	0.40	384,685	0.54	69
71	Medical Supplies Charged to Patients	385,891	0.55	180,057	0.54	565,948	0.80	71
72	Impl. Dev. Charged to Patients	282,013	0.40	131,587	0.39	413,600	0.58	72
73	Drugs Charged to Patients	1,837,651	2.60	1,539,651	4.59	3,377,302	4.78	73
74	Renal Dialysis	349,083	0.49	572,844	1.71	921,927	1.30	74
76	OP PSYCH	164,150	0.23	201,100	0.60	365,250	0.52	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
91	Emergency	5,374,430	7.60	2,805,738	8.36	8,180,168	11.57	91
92	Observation Beds (Non-Distinct Part)							92
93.01	CANCER CENTER							93.01
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,287,848	6.06	4,526,088	13.49	8,813,936	12.46	192
194	OTHER NON REIMBURSEABLE COST CENTER	249,009	0.35	102,029	0.30	351,038	0.50	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	70,726,503	100.00			70,726,503	100.00	202

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	260,990	8,463,981	0.030835	1,027,824	31,693	50
52	Delivery Room & Labor Room	46,204	472,025	0.097885			52
54	Radiology-Diagnostic	188,098	10,007,519	0.018796	1,374,888	25,842	54
55.01	CHEMO THERAPY	287	289,953	0.000990	5,582	6	55.01
56	Radioisotope	40,740	1,212,382	0.033603	310,270	10,426	56
57	CT Scan	29,256	22,135,725	0.001322	2,570,546	3,398	57
60	Laboratory	87,133	59,038,384	0.001476	8,763,069	12,934	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	80,957	12,628,995	0.006410	2,951,613	18,920	65
66	Physical Therapy	73,605	1,654,372	0.044491	209,604	9,325	66
69	Electrocardiology	2,532	4,289,748	0.000590	776,874	458	69
71	Medical Supplies Charged to Pat	29,481	960,037	0.030708	117,707	3,615	71
72	Impl. Dev. Charged to Patients	21,545	516,107	0.041745	74,483	3,109	72
73	Drugs Charged to Patients	48,123	18,380,053	0.002618	3,790,561	9,924	73
74	Renal Dialysis	176,918	4,064,653	0.043526	967,775	42,123	74
76	OP PSYCH	41,208	1,249,931	0.032968			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
91	Emergency	197,957	15,625,004	0.012669	1,162,957	14,734	91
92	Observation Beds (Non-Distinct	101,753	8,056,884	0.012629			92
93.01	CANCER CENTER						93.01
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL	1,426,787	169,045,753		24,103,753	186,507	200

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ROUTINE SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	SWING-BED ADJUST- MENT AMOUNT	REDUCED CAPITAL RELATED COST	TOTAL PATIENT DAYS	PER DIEM	INPATIENT PROGRAM DAYS	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics	999,021		999,021	20,294	49.23	3,732	183,726	30
31	Intensive Care Unit	109,469		109,469	2,059	53.17	572	30,413	31
200	TOTAL	1,108,490		1,108,490	22,353		4,304	214,139	200

MEDICARE INPATIENT ROUTINE SERVICE PPS CAPITAL COSTS	214,139
MEDICARE INPATIENT ANCILLARY SERVICE PPS CAPITAL COSTS	186,507
TOTAL MEDICARE INPATIENT PPS CAPITAL COSTS	400,646
MEDICARE DISCHARGES (Worksheet S-3, Part I, line 14, column 13)	835
MEDICARE PATIENT DAYS (Worksheet S-3, Part I, line 14, column 6 - Worksheet S-3, Part I, line 5, column 6)	4,304
PER DISCHARGE CAPITAL COSTS	479.82

KPMG LLP Compu-Max 2552-10

NOT APPROVED FOR SUBMISSION Provider CCN: 14-0177	Non CMS worksheet CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/28/2018 Run Time: 14:35 Version: 2018.04 (08/22/2018)
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I. COST TO CHARGE RATIO FOR PPS HOSPITALS

1. TOTAL PROGRAM (Title XVIII) INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COST. (Worksheet D-1, Part II, line 53)	7,717,008
2. HOSPITAL PART A TITLE XVIII CHARGES (sum of inpatient charges and ancillary charges on Worksheet D-3 for hospital Title XVIII component)	38,681,329
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.200

COST TO CHARGE RATIO FOR PSYCH SUBPROVIDER

1. TOTAL MEDICARE COSTS (Worksheet D-1, Part II, line 49 - (Worksheet D, Part III, column 9, line 40 + Worksheet D, Part IV, column 11, line 200))	1,385,598
2. TOTAL MEDICARE CHARGES (Worksheet D-3, line 40, column 2 plus Worksheet D-3, line 202, column 2) (see CR 5619)	
3. RATIO OF COST TO CHARGES (line 1 / line 2)	

II. COST TO CHARGE RATIO FOR CAPITAL

1. TOTAL MEDICARE INPATIENT PPS CAPITAL RELATED COSTS (Worksheet D, Part I, lines 30-35, column 7 + Worksheet D, Part II, line 200, column 5)	400,646
2. RATIO OF COST TO CHARGES (line II-1 / line I-2)	0.010

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)	1,162,017
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)	6,281,409
3. RATIO OF COST TO CHARGES (line 1 / line 2)	0.185