

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/29/2018 8:10 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 11/29/2018	Time: 8:10 pm
	2. ☐ Manually submitted cost report		
	3. <input type="0"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="F"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="1"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="N"/> Initial Report for this Provider CCN 9. <input type="N"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="0"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. ALEXIUS MEDICAL CENTER (14-0290) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) HENRY ZEISEL

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	613,426	167,874	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	613,426	167,874	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0290		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 8:07 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1555 BARRINGTON ROAD			PO Box:				1.00	
2.00	City: HOFFMAN ESTATES			State: IL		Zip Code: 60194		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			ST. ALEXIUS MEDICAL CENTER	140290	16974	1	09/16/1979	N P O
4.00	Subprovider - IPF								4.00
5.00	Subprovider - IRF								5.00
6.00	Subprovider - (Other)								6.00
7.00	Swing Beds - SNF								7.00
8.00	Swing Beds - NF								8.00
9.00	Hospital-Based SNF								9.00
10.00	Hospital-Based NF								10.00
11.00	Hospital-Based OLTC								11.00
12.00	Hospital-Based HHA								12.00
13.00	Separately Certified ASC								13.00
14.00	Hospital-Based Hospice								14.00
15.00	Hospital-Based Health Clinic - RHC								15.00
16.00	Hospital-Based Health Clinic - FQHC								16.00
17.00	Hospital-Based (CMHC) I								17.00
18.00	Renal Dialysis								18.00
19.00	Other								19.00
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)						1		21.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3	N	23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			5,905	2,861	39	0	11,730	0
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 8:07 pm		
			Urban/Rural S	Date of Geogr		
			1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1	07/01/2016		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
			Beginning:	Ending:		
			1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
			Y/N	Y/N		
			1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N		40.00
			V	XVIII	XIX	
			1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00
			Y/N	IME	Direct GME	
			1.00	2.00	3.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 8:07 pm	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	4,526,776	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149019		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0290		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 8:07 pm	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: ALEXIAN BROTHERS HOSPITAL NETWORK		Contractor's Name: WPS		Contractor's Number: 05901				141.00
142.00	Street: 3040 SALT CREEK LANE		PO Box:						142.00
143.00	City: ARLINGTON HEIGHTS,		State: IL		Zip Code: 60005		143.00		
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N		146.00		
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		155.00
156.00	Subprovider - IPF			N	N	N	N		156.00
157.00	Subprovider - IRF			N	N	N	N		157.00
158.00	SUBPROVIDER								158.00
159.00	SNF			N	N	N	N		159.00
160.00	HOME HEALTH AGENCY			N	N	N	N		160.00
161.00	CMHC				N	N	N		161.00
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
				Name	County	State	Zip Code	CBSA	FTE/Campus
				0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.00
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								0168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							0.25	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2015	09/30/2016		170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N		0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0290		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/29/2018 8:07 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	10/18/2018	N	10/18/2018
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-2
Part II
Date/Time Prepared:
11/29/2018 8:07 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARY JO		MACKNISKAS	41.00
42.00	Enter the employer/company name of the cost report preparer.	AMITA HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-312-7270		MARYJO.MACKNISKAS@AMITAHEALT H.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/29/2018 8:07 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-3
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
1.00	30.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		267	97,455	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		267	97,455	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	35	12,775	0.00	0	8.00
8.01 NEONATAL NICU	31.01	16	5,840	0.00	0	8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		318	116,070	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		318				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-3
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	21,545	2,949	58,764			1.00
2.00	HMO and other (see instructions)	6,150	15,036				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	21,545	2,949	58,764			7.00
8.00	INTENSIVE CARE UNIT	1,876	406	4,578			8.00
8.01	NEONATAL NICU	0	0	7,648			8.01
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		2,144	6,795			13.00
14.00	Total (see instructions)	23,421	5,499	77,785	0.00	1,505.90	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,505.90	27.00
28.00	Observation Bed Days		0	11,096			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	1			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-3
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	4,581	864	16,570	1.00
2.00 HMO and other (see instructions)			1,129	1,238		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
8.01 NEONATAL NICU						8.01
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	4,581	864	16,570	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-3
Part II
Date/Time Prepared:
11/29/2018 8:07 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	98,434,146	0	98,434,146	3,132,262.00	31.43
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		389,668	0	389,668	24,459.00	15.93
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,358,393	0	1,358,393	23,446.00	57.94
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		2,726,721	0	2,726,721	18,178.00	150.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		10,608,503	0	10,608,503	175,302.00	60.52
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		20,951,386	0	20,951,386		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		82,000	0	82,000		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	807,830	0	807,830	1.68	480,851.19
27.00	Administrative & General	5.00	5,049,144	0	5,049,144	117.23	43,070.41

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-3
Part II
Date/Time Prepared:
11/29/2018 8:07 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	0	0	0.00	0.00	32.00
33.00	Housekeeping under contract (see instructions)	3,837,932	0	3,837,932	154,050.00	24.91	33.00
34.00	Dietary	10.00	68,270	-20,481	47,789	0.00	34.00
35.00	Dietary under contract (see instructions)	3,818,213	0	3,818,213	145,298.00	26.28	35.00
36.00	Cafeteria	11.00	0	20,481	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,588,353	0	1,588,353	32,846.00	38.00
39.00	Central Services and Supply	14.00	435,049	0	435,049	21,603.00	39.00
40.00	Pharmacy	15.00	3,820,055	0	3,820,055	89,573.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,026,571	0	1,026,571	51,792.00	41.00
42.00	Social Service	17.00	2,310,845	0	2,310,845	58,844.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-3
Part III
Date/Time Prepared:
11/29/2018 8:07 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	106,090,291	0	106,090,291	3,431,610.00	30.92	1.00
2.00	Excluded area salaries (see instructions)	389,668	0	389,668	24,459.00	15.93	2.00
3.00	Subtotal salaries (line 1 minus line 2)	105,700,623	0	105,700,623	3,407,151.00	31.02	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,693,617	0	14,693,617	216,926.00	67.74	4.00
5.00	Subtotal wage-related costs (see inst.)	20,951,386	0	20,951,386	0.00	19.82	5.00
6.00	Total (sum of lines 3 thru 5)	141,345,626	0	141,345,626	3,624,077.00	39.00	6.00
7.00	Total overhead cost (see instructions)	22,762,262	0	22,762,262	554,124.91	41.08	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/29/2018 8:07 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			1,941,444 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			72,798 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			10,644,109 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			-93,195 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			-134,317 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			279,068 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			799,744 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			7,217,507 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			224,228 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			20,951,386 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet S-3
Part V
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,358,393	0	1.00
2.00	Hospital	1,358,393	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet S-10

Date/Time Prepared:
11/29/2018 8:07 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.189344	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		55,478,855	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		319,274,540	6.00
7.00	Medicaid cost (line 1 times line 6)		60,452,719	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		4,973,864	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,973,864	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	22,300,895	1,397,444	23,698,339
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,222,541	1,397,444	5,619,985
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	4,222,541	1,397,444	5,619,985
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		15,508,253	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,103,218	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,697,259	27.01
28.00	Non-Medicare bad debt expense (see instructions)		13,810,994	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,209,070	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		8,829,055	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		13,802,919	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		10,136,079	10,136,079	10,339,862	20,475,941 1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		5,482,534	5,482,534	3,688,299	9,170,833 2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	807,830	13,467,565	14,275,395	450,600	14,725,995 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,049,144	88,401,179	93,450,323	-1,751,480	91,698,843 5.00
7.00	00700	OPERATION OF PLANT	0	7,505,341	7,505,341	0	7,505,341 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	638,994	638,994 8.00
9.00	00900	HOUSEKEEPING	0	5,484,252	5,484,252	-649,155	4,835,097 9.00
10.00	01000	DIETARY	68,270	4,858,134	4,926,404	-1,477,921	3,448,483 10.00
11.00	01100	CAFETERIA	0	660,789	660,789	1,477,921	2,138,710 11.00
13.00	01300	NURSING ADMINISTRATION	1,588,353	803,942	2,392,295	-321,388	2,070,907 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	435,049	616,621	1,051,670	-507,451	544,219 14.00
15.00	01500	PHARMACY	3,820,055	13,794,646	17,614,701	-13,164,632	4,450,069 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,026,571	362,341	1,388,912	-2,112	1,386,800 16.00
17.00	01700	SOCIAL SERVICE	2,310,845	284,214	2,595,059	0	2,595,059 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	30,039,297	5,127,148	35,166,445	-1,483,459	33,682,986 30.00
31.00	03100	INTENSIVE CARE UNIT	4,741,397	1,152,613	5,894,010	-504,733	5,389,277 31.00
31.01	02060	NEONATAL NICU	6,859,546	1,862,938	8,722,484	-677,356	8,045,128 31.01
43.00	04300	NURSERY	821,014	96,293	917,307	-27,743	889,564 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,469,356	19,912,183	25,381,539	-18,578,628	6,802,911 50.00
50.01	05001	ENDOSCOPY	1,071,927	1,335,261	2,407,188	-1,186,972	1,220,216 50.01
51.00	05100	RECOVERY ROOM	1,067,844	162,076	1,229,920	-56,461	1,173,459 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,219,923	1,245,110	5,465,033	-626,932	4,838,101 52.00
53.00	05300	ANESTHESIOLOGY	104,226	482,029	586,255	-367,985	218,270 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,937,544	605,507	2,543,051	-161,763	2,381,288 54.00
54.01	03630	ULTRASOUND	1,135,492	198,545	1,334,037	-52,799	1,281,238 54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	594,808	663,331	1,258,139	-601,457	656,682 54.02
54.03	03440	MAMMOGRAPHY	1,133,247	438,929	1,572,176	-144,163	1,428,013 54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	619,892	258,831	878,723	-212,656	666,067 55.00
56.00	05600	RADIOISOTOPE	424,856	1,486,156	1,911,012	-1,438,530	472,482 56.00
57.00	05700	CT SCAN	1,119,866	485,478	1,605,344	-301,012	1,304,332 57.00
58.00	05800	MRI	797,206	619,618	1,416,824	-521,740	895,084 58.00
59.00	05900	CARDIAC CATHETERIZATION	1,297,820	2,463,964	3,761,784	-2,307,116	1,454,668 59.00
60.00	06000	LABORATORY	2,539,617	5,439,573	7,979,190	-125,542	7,853,648 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	338,262	839,768	1,178,030	-1,999	1,176,031 63.00
64.00	06400	INTRAVENOUS THERAPY	313,853	311,849	625,702	-291,090	334,612 64.00
65.00	06500	RESPIRATORY THERAPY	1,585,569	1,219,355	2,804,924	-557,740	2,247,184 65.00
66.00	06600	PHYSICAL THERAPY	2,460,292	220,895	2,681,187	-8,473	2,672,714 66.00
66.01	06601	REHAB OUTPATIENT	1,673,547	519,451	2,192,998	-19,705	2,173,293 66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	917,070	116,464	1,033,534	-32,032	1,001,502 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	179,004	31,053	210,057	-14,339	195,718 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	19,560,925	19,560,925 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,890,187	10,890,187 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,314,502	11,314,502 73.00
74.00	07400	RENAL DIALYSIS	716	876,283	876,999	-4,772	872,227 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	15	15	0	15 90.01
90.02	09001	PROCEDURE CLINIC	1,851,725	281,768	2,133,493	-109,424	2,024,069 90.02
90.04	09002	EPILEPSY MONITORING UNIT	198,164	23,909	222,073	-4,190	217,883 90.04
90.05	09003	OFFSITE IMAGING CENTER	399,306	283,895	683,201	-41,265	641,936 90.05
91.00	09100	EMERGENCY	7,025,975	3,200,718	10,226,693	-1,064,579	9,162,114 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		8,960,496	8,960,496	-8,960,496	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	98,044,478	212,779,139	310,823,617	0	310,823,617 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	98,637	647,320	745,957	0	745,957 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	119,113	56,100	175,213	0	175,213 192.00
192.01	19201	POB	0	4,293,552	4,293,552	0	4,293,552 192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0 194.00
194.01	07951	RETAIL PHARMACY	171,918	20,664	192,582	0	192,582 194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	98,434,146	217,796,775	316,230,921	0	316,230,921 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-9,131,606	11,344,335	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,415,366	11,586,199	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,725,995	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-8,396,762	83,302,081	5.00
7.00	00700	OPERATION OF PLANT	127,867	7,633,208	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	638,994	8.00
9.00	00900	HOUSEKEEPING	0	4,835,097	9.00
10.00	01000	DIETARY	0	3,448,483	10.00
11.00	01100	CAFETERIA	-1,039,596	1,099,114	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,070,907	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	544,219	14.00
15.00	01500	PHARMACY	0	4,450,069	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-9,754	1,377,046	16.00
17.00	01700	SOCIAL SERVICE	0	2,595,059	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	325,637	34,008,623	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,389,277	31.00
31.01	02060	NEONATAL NICU	0	8,045,128	31.01
43.00	04300	NURSERY	0	889,564	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,802,911	50.00
50.01	05001	ENDOSCOPY	0	1,220,216	50.01
51.00	05100	RECOVERY ROOM	0	1,173,459	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,838,101	52.00
53.00	05300	ANESTHESIOLOGY	0	218,270	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,381,288	54.00
54.01	03630	ULTRASOUND	0	1,281,238	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	656,682	54.02
54.03	03440	MAMMOGRAPHY	0	1,428,013	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	666,067	55.00
56.00	05600	RADIOISOTOPE	0	472,482	56.00
57.00	05700	CT SCAN	0	1,304,332	57.00
58.00	05800	MRI	0	895,084	58.00
59.00	05900	CARDIAC CATHETERIZATION	-4,913	1,449,755	59.00
60.00	06000	LABORATORY	-14,217	7,839,431	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,176,031	63.00
64.00	06400	INTRAVENOUS THERAPY	0	334,612	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,247,184	65.00
66.00	06600	PHYSICAL THERAPY	0	2,672,714	66.00
66.01	06601	REHAB OUTPATIENT	0	2,173,293	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,001,502	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	195,718	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,560,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,890,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,314,502	73.00
74.00	07400	RENAL DIALYSIS	0	872,227	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	15	90.01
90.02	09001	PROCEDURE CLINIC	0	2,024,069	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	217,883	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	641,936	90.05
91.00	09100	EMERGENCY	-945,380	8,216,734	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-16,673,358	294,150,259	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-437,975	307,982	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	175,213	192.00
192.01	19201	POB	-4,663,054	-369,502	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	192,582	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	-21,774,387	294,456,534	200.00

RECLASSIFICATIONS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/29/2018 8:07 pm

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
A - RECLASS LEASE EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,379,366		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,688,299		2.00
3.00	RADIOLOGY-THERAPEUTIC	55.00	0	35,250		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	6,884		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
0			0	5,109,799		
B - RECLASS MEDICAL SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	19,560,925		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	130,432		2.00
3.00	NURSING ADMINISTRATION	13.00	0	167,012		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
0			0	19,858,369		
C - RECLASS CHARGEABLE DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,314,502		1.00
0			0	11,314,502		
E - RECLASS LAUNDRY COSTS						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	638,994		1.00
0			0	638,994		
F - RECLASS CAFETERIA COSTGS						
1.00	CAFETERIA	11.00	20,481	1,457,440		1.00
0			20,481	1,457,440		
G - RECLASS WORKERS COMPENSATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	450,600		1.00
0			0	450,600		
H - RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,960,496		1.00
0			0	8,960,496		
J - IMPLANT RECLASS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	10,890,187		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00

RECLASSIFICATIONS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/29/2018 8:07 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	0		0	10,890,187	
500.00	Grand Total: Increases		20,481	58,680,387	500.00

RECLASSIFICATIONS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/29/2018 8:07 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			10.00
	A - RECLASS LEASE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,379,140	10	1.00	
2.00	HOUSEKEEPING	9.00	0	10,161	10	2.00	
3.00	NURSING ADMINISTRATION	13.00	0	488,364	0	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	264,154	0	4.00	
5.00	PHARMACY	15.00	0	847,893	0	5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	9,823	0	6.00	
7.00	NEONATAL NICU	31.01	0	163,958	0	7.00	
8.00	OPERATING ROOM	50.00	0	683,202	0	8.00	
9.00	ENDOSCOPY	50.01	0	529,422	0	9.00	
10.00	MAMMOGRAPHY	54.03	0	67,437	0	10.00	
11.00	CT SCAN	57.00	0	85,460	0	11.00	
12.00	MRI	58.00	0	303,532	0	12.00	
13.00	RESPIRATORY THERAPY	65.00	0	244,781	0	13.00	
14.00	OFFSITE IMAGING CENTER	90.05	0	32,472	0	14.00	
	0		0	5,109,799			
	B - RECLASS MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	239,477	0	1.00	
2.00	PHARMACY	15.00	0	1,002,237	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	1,468,471	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	497,559	0	4.00	
5.00	NEONATAL NICU	31.01	0	512,566	0	5.00	
6.00	NURSERY	43.00	0	27,743	0	6.00	
7.00	OPERATING ROOM	50.00	0	8,113,048	0	7.00	
8.00	ENDOSCOPY	50.01	0	596,871	0	8.00	
9.00	RECOVERY ROOM	51.00	0	56,427	0	9.00	
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	591,000	0	10.00	
11.00	ANESTHESIOLOGY	53.00	0	367,985	0	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	161,763	0	12.00	
13.00	ULTRASOUND	54.01	0	52,799	0	13.00	
14.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	502,508	0	14.00	
15.00	MAMMOGRAPHY	54.03	0	76,726	0	15.00	
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	247,906	0	16.00	
17.00	RADIOISOTOPE	56.00	0	1,438,530	0	17.00	
18.00	CT SCAN	57.00	0	214,255	0	18.00	
19.00	MRI	58.00	0	218,208	0	19.00	
20.00	CARDIAC CATHETERIZATION	59.00	0	1,488,597	0	20.00	
21.00	LABORATORY	60.00	0	125,542	0	21.00	
22.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,999	0	22.00	
23.00	INTRAVENOUS THERAPY	64.00	0	291,090	0	23.00	
24.00	RESPIRATORY THERAPY	65.00	0	312,959	0	24.00	
25.00	PHYSICAL THERAPY	66.00	0	8,473	0	25.00	
26.00	REHAB OUTPATIENT	66.01	0	19,648	0	26.00	
27.00	ELECTROCARDIOLOGY	69.00	0	32,032	0	27.00	
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	14,339	0	28.00	
29.00	RENAL DIALYSIS	74.00	0	4,647	0	29.00	
30.00	PROCEDURE CLINIC	90.02	0	106,119	0	30.00	
31.00	EPILEPSY MONITORING UNIT	90.04	0	4,190	0	31.00	
32.00	OFFSITE IMAGING CENTER	90.05	0	8,793	0	32.00	
33.00	EMERGENCY	91.00	0	1,053,862	0	33.00	
	0		0	19,858,369			
	C - RECLASS CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	11,314,502	0	1.00	
	0		0	11,314,502			
	E - RECLASS LAUNDRY COSTS						
1.00	HOUSEKEEPING	9.00	0	638,994	0	1.00	
	0		0	638,994			
	F - RECLASS CAFETERIA COSTGS						
1.00	DIETARY	10.00	20,481	1,457,440	0	1.00	
	0		20,481	1,457,440			
	G - RECLASS WORKERS COMPENSATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	450,600	0	1.00	
	0		0	450,600			
	H - RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	8,960,496	11	1.00	
	0		0	8,960,496			
	J - IMPLANT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	52,172	0	1.00	
2.00	NURSING ADMINISTRATION	13.00	0	36	0	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,820	0	3.00	
4.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,112	0	4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	5,165	0	5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	7,174	0	6.00	

RECLASSIFICATIONS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-6

Date/Time Prepared:
11/29/2018 8:07 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
7.00	NEONATAL NICU	31.01	0	832	0	7.00
8.00	OPERATING ROOM	50.00	0	9,782,378	0	8.00
9.00	ENDOSCOPY	50.01	0	60,679	0	9.00
10.00	RECOVERY ROOM	51.00	0	34	0	10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	35,932	0	11.00
12.00	RADIOLOGY-SPECIAL PROCEDURES	54.02	0	98,949	0	12.00
13.00	CT SCAN	57.00	0	1,297	0	13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	825,403	0	14.00
15.00	REHAB OUTPATIENT	66.01	0	57	0	15.00
16.00	RENAL DIALYSIS	74.00	0	125	0	16.00
17.00	PROCEDURE CLINIC	90.02	0	3,305	0	17.00
18.00	EMERGENCY	91.00	0	10,717	0	18.00
	0		0	10,890,187		
500.00	Grand Total: Decreases		20,481	58,680,387		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet A-7
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	12,220,000	0	0	0	0	1.00	
2.00	Land Improvements	192,467	0	0	0	0	2.00	
3.00	Buildings and Fixtures	223,679,530	829,261	0	829,261	0	3.00	
4.00	Building Improvements	32,996,867	184,241	0	184,241	0	4.00	
5.00	Fixed Equipment	1,463,246	0	0	0	0	5.00	
6.00	Movable Equipment	46,226,019	10,692,684	0	10,692,684	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	316,778,129	11,706,186	0	11,706,186	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	316,778,129	11,706,186	0	11,706,186	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	12,220,000	0					1.00
2.00	Land Improvements	192,467	0					
3.00	Buildings and Fixtures	224,508,791	0					
4.00	Building Improvements	33,181,108	0					4.00
5.00	Fixed Equipment	1,463,246	0					
6.00	Movable Equipment	56,918,703	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	328,484,315	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	328,484,315	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet A-7
Part II
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	10,136,079	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,482,534	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	15,618,613	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	10,136,079				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,482,534				2.00
3.00	Total (sum of lines 1-2)	0	15,618,613				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet A-7
Part III
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	271,565,612	0	271,565,612	0.826723	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	56,918,703	0	56,918,703	0.173277	0	2.00
3.00	Total (sum of lines 1-2)	328,484,315	0	328,484,315	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	9,964,969	1,379,366	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,897,900	3,688,299	2.00
3.00	Total (sum of lines 1-2)	0	0	0	17,862,869	5,067,665	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	11,344,335	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	11,586,199	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	22,930,534	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,310,677			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-8,829,286			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-946,898	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-9,754	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-92,698	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	-997,724	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-7,840	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.01	CAFETERIA REVENUE	B	-437,975	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	34.01
34.02	LAB OTHER REVENUE	B	-14,217	LABORATORY	60.00	0	34.02
34.03	LAB OTHER REVENUE	B		LABORATORY	60.00	0	34.03
34.04	LAB OTHER REVENUE	B		LABORATORY	60.00	0	34.04
34.05	LAB OTHER REVENUE	B		LABORATORY	60.00	0	34.05
34.06	LAB OTHER REVENUE	B		LABORATORY	60.00	0	34.06
35.00	ITC RENT REV ABSG	B	-949,171	POB	192.01	0	35.00
36.00	ITC RENT REV ABAG	B		POB	192.01	0	36.00
37.00	ITC RENT REV ABSG	B		POB	192.01	0	37.00
40.00	PERINATAL CLASS TUITION	B	-50,557	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	OTHER EDUCATION	B		ADMINISTRATIVE & GENERAL	5.00	0	41.00
43.00	AUDIT RECOVERIES	B		ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01	ITC RENT REV	B	-514,590	ADMINISTRATIVE & GENERAL	5.00	0	43.01
43.02	ITC RENT REV ABSG	B		ADMINISTRATIVE & GENERAL	5.00	0	43.02
43.03	MEDICAID TAXES		0		0.00	0	43.03
43.04	MISCELLANEOUS INCOME	B	-136,186	OPERATION OF PLANT	7.00	0	43.04
43.06	RENT PHYS OFFICE	B	-372,185	POB	192.01	0	43.06
43.07	RENT PHYS OFFICE	B		POB	192.01	0	43.07
43.11	RENT PHYS OFFICE	B		POB	192.01	0	43.11
43.12	RENT PHYS OFFICE	B		POB	192.01	0	43.12
43.13	MISC INCOME	B	-424,372	ADMINISTRATIVE & GENERAL	5.00	0	43.13
43.14	COMMUNITY TRANSPORT	A		ADMINISTRATIVE & GENERAL	5.00	0	43.14
43.15	R/E TAXES	A	-293,677	ADMINISTRATIVE & GENERAL	5.00	0	43.15
43.16	CONTRIBUTIONS	A		ADMINISTRATIVE & GENERAL	5.00	0	43.16
43.17	ER DIRECT PT SVSC	A	-945,380	EMERGENCY	91.00	0	43.17
43.18	NON PATIENT RELATED COSTS	A	-49,502	ADMINISTRATIVE & GENERAL	5.00	0	43.18
43.19	OFFSET PHYSICIAN FEES	A		PHYSICIANS' PRIVATE OFFICES	192.00	0	43.19
43.20	OFFSET PHYSICIAN FEES	A	-3,341,698	POB	192.01	0	43.20
43.21	OFFSET PHYSICIAN FEES	A		POB	192.01	0	43.21
43.22	OFFSET PHYSICIAN FEES	A		POB	192.01	0	43.22
43.23	LOBBY DUES	A	-50,000	ADMINISTRATIVE & GENERAL	5.00	0	43.23
43.24	NON PATIENT RELATED COSTS	A		ADMINISTRATIVE & GENERAL	5.00	0	43.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-21,774,387				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8-1

Date/Time Prepared:
11/29/2018 8:07 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST CAP	0	8,960,496	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ABHN CAP BUILDING	826,614	0	2.00
3.00	2.00	CAP REL COSTS-MVBLE EQUIP	ABHN CAP EQUIPMENT	2,423,206	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	ADMIN COSTS	54,277,668	57,985,968	3.01
3.02	7.00	OPERATION OF PLANT	CLINICAL ENG AND FACILITY AD	264,053	0	3.02
3.03	30.00	ADULTS & PEDIATRICS	PEDIATRIC	325,637	0	3.03
3.04	0.00			0	0	3.04
3.05	0.00			0	0	3.05
3.06	0.00			0	0	3.06
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			58,117,178	66,946,464	5.00

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

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

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

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

6.00	B		0.00	PRESENCE ABHS	100.00	6.00
7.00	B		0.00	ABHN	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				0.00	100.00

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

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

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

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8-1

Date/Time Prepared:
11/29/2018 8:07 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-8,960,496	11		1.00
2.00	826,614	9		2.00
3.00	2,423,206	9		3.00
3.01	-3,708,300	0		3.01
3.02	264,053	0		3.02
3.03	325,637	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
4.00	0	0		4.00
5.00	-8,829,286			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet A-8-2

Date/Time Prepared:
11/29/2018 8:07 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	3,305,764	3,305,764	0	0	0	1.00
2.00	59.00	CARDIAC CATHETERIZATION	4,913	4,913	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,310,677	3,310,677	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	3,305,764		1.00
2.00	59.00	CARDIAC CATHETERIZATION	0	0	0	4,913		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	3,310,677		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
Net Expenses for Cost Allocation (from Wkst A col. 7)							
0			1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,344,335	11,344,335			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	11,586,199	11,586,199			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,725,995	8,060	8,317	14,742,372	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	83,302,081	1,039,036	951,912	762,461	5.00
7.00	00700	OPERATION OF PLANT	7,633,208	3,094,198	3,192,978	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	638,994	0	0	0	8.00
9.00	00900	HOUSEKEEPING	4,835,097	130,090	134,243	0	9.00
10.00	01000	DIETARY	3,448,483	115,653	119,345	7,217	10.00
11.00	01100	CAFETERIA	1,099,114	83,942	86,622	3,093	11.00
13.00	01300	NURSING ADMINISTRATION	2,070,907	184,669	190,564	239,854	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	544,219	58,198	60,056	65,696	14.00
15.00	01500	PHARMACY	4,450,069	84,470	87,167	576,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,377,046	129,209	133,334	155,020	16.00
17.00	01700	SOCIAL SERVICE	2,595,059	5,654	5,834	348,956	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	34,008,623	2,593,716	2,676,518	4,536,192	30.00
31.00	03100	INTENSIVE CARE UNIT	5,389,277	211,039	217,776	715,989	31.00
31.01	02060	NEONATAL NICU	8,045,128	384,655	396,935	1,035,846	31.01
43.00	04300	NURSERY	889,564	25,040	25,839	123,980	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,802,911	644,463	665,037	825,917	50.00
50.01	05001	ENDOSCOPY	1,220,216	207,537	214,163	161,870	50.01
51.00	05100	RECOVERY ROOM	1,173,459	110,801	114,338	161,253	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,838,101	293,259	302,622	637,242	52.00
53.00	05300	ANESTHESIOLOGY	218,270	10,348	10,679	15,739	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,381,288	287,704	296,888	292,585	54.00
54.01	03630	ULTRASOUND	1,281,238	21,949	22,650	171,468	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	656,682	20,149	20,792	89,821	54.02
54.03	03440	MAMMOGRAPHY	1,428,013	95,993	99,057	171,129	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	666,067	243,121	250,883	93,609	55.00
56.00	05600	RADIOISOTOPE	472,482	41,609	42,937	64,157	56.00
57.00	05700	CT SCAN	1,304,332	52,114	53,778	169,109	57.00
58.00	05800	MRI	895,084	40,103	41,383	120,384	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,449,755	130,638	134,808	195,981	59.00
60.00	06000	LABORATORY	7,839,431	263,544	271,958	383,502	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,176,031	10,622	10,961	51,080	63.00
64.00	06400	INTRAVENOUS THERAPY	334,612	0	0	47,394	64.00
65.00	06500	RESPIRATORY THERAPY	2,247,184	28,111	29,009	239,434	65.00
66.00	06600	PHYSICAL THERAPY	2,672,714	104,600	107,939	371,524	66.00
66.01	06601	REHAB OUTPATIENT	2,173,293	2,328	2,402	252,719	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,001,502	0	0	138,485	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	195,718	10,877	11,224	27,031	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,560,925	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,890,187	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,314,502	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	872,227	0	0	108	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	15	0	0	0	90.01
90.02	09001	PROCEDURE CLINIC	2,024,069	124,651	128,631	279,625	90.02
90.04	09002	EPILEPSY MONITORING UNIT	217,883	0	0	29,924	90.04
90.05	09003	OFFSITE IMAGING CENTER	641,936	0	0	60,298	90.05
91.00	09100	EMERGENCY	8,216,734	405,724	418,676	1,060,978	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	294,150,259	11,297,874	11,538,255	14,683,529	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	307,982	46,461	47,944	14,895	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	175,213	0	0	17,987	192.00
192.01	19201	POB	-369,502	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	192,582	0	0	25,961	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0290

Period:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	294,456,534	11,344,335	11,586,199	14,742,372	294,456,534	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	86,055,490					5.00
7.00	00700	OPERATION OF PLANT	5,737,996	19,658,380				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	263,394	0	902,388			8.00
9.00	00900	HOUSEKEEPING	2,101,990	355,038	0	7,556,458		9.00
10.00	01000	DIETARY	1,521,309	315,637	0	123,559	5,651,203	10.00
11.00	01100	CAFETERIA	524,637	229,093	0	89,680	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,107,169	503,994	0	197,293	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	300,152	158,833	0	62,176	0	14.00
15.00	01500	PHARMACY	2,142,854	230,535	0	90,245	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	739,740	352,636	0	138,042	0	16.00
17.00	01700	SOCIAL SERVICE	1,218,261	15,429	0	6,040	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,060,669	7,078,712	514,167	2,771,021	5,140,430	30.00
31.00	03100	INTENSIVE CARE UNIT	2,693,355	575,963	45,086	225,465	510,773	31.00
31.01	02060	NEONATAL NICU	4,065,359	1,049,792	7,731	410,950	0	31.01
43.00	04300	NURSERY	438,756	68,338	0	26,752	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,684,388	1,758,853	106,745	688,518	0	50.00
50.01	05001	ENDOSCOPY	743,522	566,406	0	221,724	0	50.01
51.00	05100	RECOVERY ROOM	642,972	302,396	0	118,376	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,502,565	800,357	57,627	313,307	0	52.00
53.00	05300	ANESTHESIOLOGY	105,126	28,243	0	11,056	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,343,143	785,195	2,220	307,371	0	54.00
54.01	03630	ULTRASOUND	617,191	59,903	25,717	23,449	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	324,585	54,991	0	21,527	0	54.02
54.03	03440	MAMMOGRAPHY	739,568	261,981	0	102,555	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	516,768	663,521	6,860	259,741	0	55.00
56.00	05600	RADIOISOTOPE	256,053	113,559	0	44,454	0	56.00
57.00	05700	CT SCAN	651,003	142,229	31,565	55,677	0	57.00
58.00	05800	MRI	452,166	109,448	0	42,844	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	787,791	356,533	0	139,568	0	59.00
60.00	06000	LABORATORY	3,610,236	719,259	0	281,560	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	514,713	28,990	0	11,349	0	63.00
64.00	06400	INTRAVENOUS THERAPY	157,463	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,048,531	76,720	0	30,033	0	65.00
66.00	06600	PHYSICAL THERAPY	1,342,447	285,472	0	111,750	0	66.00
66.01	06601	REHAB OUTPATIENT	1,001,954	6,353	0	2,487	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	469,904	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,927	29,684	0	11,620	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,063,033	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,488,946	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,663,849	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	359,577	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	6	0	0	0	0	90.01
90.02	09001	PROCEDURE CLINIC	1,053,988	340,196	0	133,173	0	90.02
90.04	09002	EPILEPSY MONITORING UNIT	102,146	0	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	289,462	0	0	0	0	90.05
91.00	09100	EMERGENCY	4,164,101	1,107,292	104,670	433,459	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85,713,765	19,531,581	902,388	7,506,821	5,651,203	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	172,004	126,799	0	49,637	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,637	0	0	0	0	192.00
192.01	19201	POB	0	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	90,084	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	86,055,490	19,658,380	902,388	7,556,458	5,651,203	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0290

Period:
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,116,181					11.00
13.00	01300	NURSING ADMINISTRATION	26,629	4,521,079				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,522	0	1,266,852			14.00
15.00	01500	PHARMACY	72,618	0	0	7,734,817		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	41,992	0	0	0	3,067,019	16.00
17.00	01700	SOCIAL SERVICE	47,709	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	755,476	2,352,247	0	0	360,979	30.00
31.00	03100	INTENSIVE CARE UNIT	94,727	294,943	0	0	43,846	31.00
31.01	02060	NEONATAL NICU	131,880	410,621	0	0	104,283	31.01
43.00	04300	NURSERY	17,050	53,087	0	0	21,770	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	117,697	366,460	0	0	271,535	50.00
50.01	05001	ENDOSCOPY	22,952	71,465	0	0	72,793	50.01
51.00	05100	RECOVERY ROOM	20,355	63,378	0	0	41,915	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	87,864	273,572	0	0	49,257	52.00
53.00	05300	ANESTHESIOLOGY	4,098	0	0	0	69,742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,089	0	0	0	86,291	54.00
54.01	03630	ULTRASOUND	20,996	0	0	0	68,053	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	10,827	0	0	0	20,877	54.02
54.03	03440	MAMMOGRAPHY	25,432	0	0	0	36,369	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	10,962	0	0	0	51,478	55.00
56.00	05600	RADIOISOTOPE	7,370	0	0	0	50,945	56.00
57.00	05700	CT SCAN	21,688	0	0	0	188,853	57.00
58.00	05800	MRI	15,819	0	0	0	90,298	58.00
59.00	05900	CARDIAC CATHETERIZATION	19,428	0	0	0	60,247	59.00
60.00	06000	LABORATORY	82,045	0	0	0	347,624	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	8,011	0	0	0	15,321	63.00
64.00	06400	INTRAVENOUS THERAPY	5,936	0	0	0	7,578	64.00
65.00	06500	RESPIRATORY THERAPY	35,989	0	0	0	67,363	65.00
66.00	06600	PHYSICAL THERAPY	42,633	0	0	0	41,552	66.00
66.01	06601	REHAB OUTPATIENT	36,006	0	0	0	25,401	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,278	0	0	0	82,013	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,700	0	0	0	10,448	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	814,245	0	132,144	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	452,607	0	51,819	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	7,734,817	275,071	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	8,543	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	0	135	90.01
90.02	09001	PROCEDURE CLINIC	35,027	109,061	0	0	22,924	90.02
90.04	09002	EPILEPSY MONITORING UNIT	4,216	13,127	0	0	1,822	90.04
90.05	09003	OFFSITE IMAGING CENTER	9,512	0	0	0	22,646	90.05
91.00	09100	EMERGENCY	164,799	513,118	0	0	265,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,096,332	4,521,079	1,266,852	7,734,817	3,067,019	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,154	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,575	0	0	0	0	192.00
192.01	19201	POB	3,120	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,116,181	4,521,079	1,266,852	7,734,817	3,067,019	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	4,242,942				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,205,403	84,054,153	0	84,054,153	30.00
31.00	03100	INTENSIVE CARE UNIT	249,716	11,267,955	0	11,267,955	31.00
31.01	02060	NEONATAL NICU	417,176	16,460,356	0	16,460,356	31.01
43.00	04300	NURSERY	370,647	2,060,823	0	2,060,823	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	15,932,524	0	15,932,524	50.00
50.01	05001	ENDOSCOPY	0	3,502,648	0	3,502,648	50.01
51.00	05100	RECOVERY ROOM	0	2,749,243	0	2,749,243	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,155,773	0	10,155,773	52.00
53.00	05300	ANESTHESIOLOGY	0	473,301	0	473,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,835,774	0	5,835,774	54.00
54.01	03630	ULTRASOUND	0	2,312,614	0	2,312,614	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	1,220,251	0	1,220,251	54.02
54.03	03440	MAMMOGRAPHY	0	2,960,097	0	2,960,097	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,763,010	0	2,763,010	55.00
56.00	05600	RADIOISOTOPE	0	1,093,566	0	1,093,566	56.00
57.00	05700	CT SCAN	0	2,670,348	0	2,670,348	57.00
58.00	05800	MRI	0	1,807,529	0	1,807,529	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,274,749	0	3,274,749	59.00
60.00	06000	LABORATORY	0	13,799,159	0	13,799,159	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,827,078	0	1,827,078	63.00
64.00	06400	INTRAVENOUS THERAPY	0	552,983	0	552,983	64.00
65.00	06500	RESPIRATORY THERAPY	0	3,802,374	0	3,802,374	65.00
66.00	06600	PHYSICAL THERAPY	0	5,080,631	0	5,080,631	66.00
66.01	06601	REHAB OUTPATIENT	0	3,502,943	0	3,502,943	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,714,182	0	1,714,182	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	403,229	0	403,229	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	28,570,347	0	28,570,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,883,559	0	15,883,559	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,988,239	0	23,988,239	73.00
74.00	07400	RENAL DIALYSIS	0	1,240,455	0	1,240,455	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	156	0	156	90.01
90.02	09001	PROCEDURE CLINIC	0	4,251,345	0	4,251,345	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	369,118	0	369,118	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	1,023,854	0	1,023,854	90.05
91.00	09100	EMERGENCY	0	16,854,635	0	16,854,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,242,942	293,459,001	0	293,459,001	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	778,876	0	778,876	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	276,412	0	276,412	192.00
192.01	19201	POB	0	-366,382	0	-366,382	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	308,627	0	308,627	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
Part I
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118 through 201)	4,242,942	294,456,534	0	294,456,534		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,060	8,317	16,377	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,039,036	951,912	1,990,948	5.00
7.00	00700	OPERATION OF PLANT	0	3,094,198	3,192,978	6,287,176	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	130,090	134,243	264,333	9.00
10.00	01000	DIETARY	0	115,653	119,345	234,998	10.00
11.00	01100	CAFETERIA	0	83,942	86,622	170,564	11.00
13.00	01300	NURSING ADMINISTRATION	0	184,669	190,564	375,233	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	58,198	60,056	118,254	14.00
15.00	01500	PHARMACY	0	84,470	87,167	171,637	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	129,209	133,334	262,543	16.00
17.00	01700	SOCIAL SERVICE	0	5,654	5,834	11,488	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	2,593,716	2,676,518	5,270,234	30.00
31.00	03100	INTENSIVE CARE UNIT	0	211,039	217,776	428,815	31.00
31.01	02060	NEONATAL NICU	0	384,655	396,935	781,590	31.01
43.00	04300	NURSERY	0	25,040	25,839	50,879	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	644,463	665,037	1,309,500	50.00
50.01	05001	ENDOSCOPY	0	207,537	214,163	421,700	50.01
51.00	05100	RECOVERY ROOM	0	110,801	114,338	225,139	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	293,259	302,622	595,881	52.00
53.00	05300	ANESTHESIOLOGY	0	10,348	10,679	21,027	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	287,704	296,888	584,592	54.00
54.01	03630	ULTRASOUND	0	21,949	22,650	44,599	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	20,149	20,792	40,941	54.02
54.03	03440	MAMMOGRAPHY	0	95,993	99,057	195,050	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	243,121	250,883	494,004	55.00
56.00	05600	RADIOISOTOPE	0	41,609	42,937	84,546	56.00
57.00	05700	CT SCAN	0	52,114	53,778	105,892	57.00
58.00	05800	MRI	0	40,103	41,383	81,486	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	130,638	134,808	265,446	59.00
60.00	06000	LABORATORY	0	263,544	271,958	535,502	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	10,622	10,961	21,583	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	28,111	29,009	57,120	65.00
66.00	06600	PHYSICAL THERAPY	0	104,600	107,939	212,539	66.00
66.01	06601	REHAB OUTPATIENT	0	2,328	2,402	4,730	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,877	11,224	22,101	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	0	90.01
90.02	09001	PROCEDURE CLINIC	0	124,651	128,631	253,282	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	405,724	418,676	824,400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,297,874	11,538,255	22,836,129	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46,461	47,944	94,405	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	POB	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
201.00		Negative Cost Centers	0	1.00	2.00	2A	4.00	
202.00		TOTAL (sum lines 118 through 201)	0	11,344,335	11,586,199	22,930,534	16,377	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,991,796					5.00
7.00	00700	OPERATION OF PLANT	132,814	6,419,990				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,097	0	6,097			8.00
9.00	00900	HOUSEKEEPING	48,654	115,948	0	428,935		9.00
10.00	01000	DIETARY	35,213	103,080	0	7,014	380,313	10.00
11.00	01100	CAFETERIA	12,144	74,817	0	5,091	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,627	164,593	0	11,199	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,947	51,871	0	3,529	0	14.00
15.00	01500	PHARMACY	49,600	75,287	0	5,123	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	17,122	115,163	0	7,836	0	16.00
17.00	01700	SOCIAL SERVICE	28,198	5,039	0	343	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	417,954	2,311,749	3,475	157,295	345,939	30.00
31.00	03100	INTENSIVE CARE UNIT	62,342	188,097	305	12,798	34,374	31.00
31.01	02060	NEONATAL NICU	94,099	342,839	52	23,327	0	31.01
43.00	04300	NURSERY	10,156	22,318	0	1,519	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	85,281	574,402	721	39,083	0	50.00
50.01	05001	ENDOSCOPY	17,210	184,976	0	12,586	0	50.01
51.00	05100	RECOVERY ROOM	14,883	98,756	0	6,719	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	57,926	261,379	389	17,785	0	52.00
53.00	05300	ANESTHESIOLOGY	2,433	9,223	0	628	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,089	256,427	15	17,448	0	54.00
54.01	03630	ULTRASOUND	14,286	19,563	174	1,331	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	7,513	17,959	0	1,222	0	54.02
54.03	03440	MAMMOGRAPHY	17,118	85,557	0	5,821	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	11,961	216,691	46	14,744	0	55.00
56.00	05600	RADIOISOTOPE	5,927	37,086	0	2,523	0	56.00
57.00	05700	CT SCAN	15,068	46,449	213	3,160	0	57.00
58.00	05800	MRI	10,466	35,743	0	2,432	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	18,235	116,436	0	7,922	0	59.00
60.00	06000	LABORATORY	83,564	234,894	0	15,982	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	11,914	9,468	0	644	0	63.00
64.00	06400	INTRAVENOUS THERAPY	3,645	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	24,270	25,055	0	1,705	0	65.00
66.00	06600	PHYSICAL THERAPY	31,073	93,229	0	6,343	0	66.00
66.01	06601	REHAB OUTPATIENT	23,192	2,075	0	141	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	10,877	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,336	9,694	0	660	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	186,631	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	103,903	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	107,952	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,323	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	0	0	90.01
90.02	09001	PROCEDURE CLINIC	24,396	111,100	0	7,559	0	90.02
90.04	09002	EPILEPSY MONITORING UNIT	2,364	0	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	6,700	0	0	0	0	90.05
91.00	09100	EMERGENCY	96,384	361,617	707	24,605	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,983,887	6,378,580	6,097	426,117	380,313	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,981	41,410	0	2,818	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,843	0	0	0	0	192.00
192.01	19201	POB	0	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	2,085	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,991,796	6,419,990	6,097	428,935	380,313	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
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Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	262,619					11.00
13.00	01300	NURSING ADMINISTRATION	3,305	580,224				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,175	0	182,849			14.00
15.00	01500	PHARMACY	9,012	0	0	311,301		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,211	0	0	0	408,047	16.00
17.00	01700	SOCIAL SERVICE	5,921	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,755	301,880	0	0	48,429	30.00
31.00	03100	INTENSIVE CARE UNIT	11,756	37,852	0	0	5,827	31.00
31.01	02060	NEONATAL NICU	16,366	52,698	0	0	13,859	31.01
43.00	04300	NURSERY	2,116	6,813	0	0	2,893	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,606	47,031	0	0	36,086	50.00
50.01	05001	ENDOSCOPY	2,848	9,172	0	0	9,674	50.01
51.00	05100	RECOVERY ROOM	2,526	8,134	0	0	5,570	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,904	35,110	0	0	6,546	52.00
53.00	05300	ANESTHESIOLOGY	509	0	0	0	9,268	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,588	0	0	0	11,468	54.00
54.01	03630	ULTRASOUND	2,606	0	0	0	9,044	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,344	0	0	0	2,774	54.02
54.03	03440	MAMMOGRAPHY	3,156	0	0	0	4,833	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	1,360	0	0	0	6,841	55.00
56.00	05600	RADIOISOTOPE	915	0	0	0	6,770	56.00
57.00	05700	CT SCAN	2,691	0	0	0	25,098	57.00
58.00	05800	MRI	1,963	0	0	0	12,000	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,411	0	0	0	8,007	59.00
60.00	06000	LABORATORY	10,182	0	0	0	46,198	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	994	0	0	0	2,036	63.00
64.00	06400	INTRAVENOUS THERAPY	737	0	0	0	1,007	64.00
65.00	06500	RESPIRATORY THERAPY	4,466	0	0	0	8,952	65.00
66.00	06600	PHYSICAL THERAPY	5,291	0	0	0	5,522	66.00
66.01	06601	REHAB OUTPATIENT	4,468	0	0	0	3,376	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,765	0	0	0	10,899	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	707	0	0	0	1,389	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	117,519	0	17,561	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	65,330	0	6,886	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	311,301	36,556	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	1,135	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	0	18	90.01
90.02	09001	PROCEDURE CLINIC	4,347	13,997	0	0	3,046	90.02
90.04	09002	EPILEPSY MONITORING UNIT	523	1,685	0	0	242	90.04
90.05	09003	OFFSITE IMAGING CENTER	1,180	0	0	0	3,009	90.05
91.00	09100	EMERGENCY	20,452	65,852	0	0	35,228	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	260,156	580,224	182,849	311,301	408,047	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,632	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	444	0	0	0	0	192.00
192.01	19201	POB	387	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	262,619	580,224	182,849	311,301	408,047	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	51,377				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	38,813	8,994,547	0	8,994,547	30.00
31.00	03100	INTENSIVE CARE UNIT	3,024	785,987	0	785,987	31.00
31.01	02060	NEONATAL NICU	5,052	1,331,034	0	1,331,034	31.01
43.00	04300	NURSERY	4,488	101,320	0	101,320	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,107,629	0	2,107,629	50.00
50.01	05001	ENDOSCOPY	0	658,346	0	658,346	50.01
51.00	05100	RECOVERY ROOM	0	361,906	0	361,906	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	986,629	0	986,629	52.00
53.00	05300	ANESTHESIOLOGY	0	43,106	0	43,106	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	907,953	0	907,953	54.00
54.01	03630	ULTRASOUND	0	91,794	0	91,794	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	71,853	0	71,853	54.02
54.03	03440	MAMMOGRAPHY	0	311,725	0	311,725	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	745,751	0	745,751	55.00
56.00	05600	RADIOISOTOPE	0	137,838	0	137,838	56.00
57.00	05700	CT SCAN	0	198,759	0	198,759	57.00
58.00	05800	MRI	0	144,224	0	144,224	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	418,675	0	418,675	59.00
60.00	06000	LABORATORY	0	926,749	0	926,749	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	46,696	0	46,696	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,442	0	5,442	64.00
65.00	06500	RESPIRATORY THERAPY	0	121,834	0	121,834	65.00
66.00	06600	PHYSICAL THERAPY	0	354,410	0	354,410	66.00
66.01	06601	REHAB OUTPATIENT	0	38,263	0	38,263	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,695	0	24,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	36,917	0	36,917	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	321,711	0	321,711	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	176,119	0	176,119	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	455,809	0	455,809	73.00
74.00	07400	RENAL DIALYSIS	0	9,458	0	9,458	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	18	0	18	90.01
90.02	09001	PROCEDURE CLINIC	0	418,038	0	418,038	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	4,847	0	4,847	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	10,956	0	10,956	90.05
91.00	09100	EMERGENCY	0	1,430,425	0	1,430,425	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	51,377	22,781,463	0	22,781,463	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	144,263	0	144,263	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,307	0	2,307	192.00
192.01	19201	POB	0	387	0	387	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	2,114	0	2,114	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet B
Part II
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
202.00	TOTAL (sum lines 118 through 201)	51,377	22,930,534	0	22,930,534		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	579,906					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		573,947				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	412	412	97,626,316			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	53,114	47,155	5,049,144	-86,055,490	208,770,546	5.00
7.00	00700	OPERATION OF PLANT	158,171	158,171	0	0	13,920,384	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	638,994	8.00
9.00	00900	HOUSEKEEPING	6,650	6,650	0	0	5,099,430	9.00
10.00	01000	DIETARY	5,912	5,912	47,789	0	3,690,698	10.00
11.00	01100	CAFETERIA	4,291	4,291	20,481	0	1,272,771	11.00
13.00	01300	NURSING ADMINISTRATION	9,440	9,440	1,588,353	0	2,685,994	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,975	2,975	435,049	0	728,169	14.00
15.00	01500	PHARMACY	4,318	4,318	3,820,055	0	5,198,565	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,605	6,605	1,026,571	0	1,794,609	16.00
17.00	01700	SOCIAL SERVICE	289	289	2,310,845	0	2,955,503	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	132,587	132,587	30,039,297	0	43,815,049	30.00
31.00	03100	INTENSIVE CARE UNIT	10,788	10,788	4,741,397	0	6,534,081	31.00
31.01	02060	NEONATAL NICU	19,663	19,663	6,859,546	0	9,862,564	31.01
43.00	04300	NURSERY	1,280	1,280	821,014	0	1,064,423	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	32,944	32,944	5,469,356	0	8,938,328	50.00
50.01	05001	ENDOSCOPY	10,609	10,609	1,071,927	0	1,803,786	50.01
51.00	05100	RECOVERY ROOM	5,664	5,664	1,067,844	0	1,559,851	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,991	14,991	4,219,923	0	6,071,224	52.00
53.00	05300	ANESTHESIOLOGY	529	529	104,226	0	255,036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,707	14,707	1,937,544	0	3,258,465	54.00
54.01	03630	ULTRASOUND	1,122	1,122	1,135,492	0	1,497,305	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	1,030	594,808	0	787,444	54.02
54.03	03440	MAMMOGRAPHY	4,907	4,907	1,133,247	0	1,794,192	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	12,428	12,428	619,892	0	1,253,680	55.00
56.00	05600	RADIOISOTOPE	2,127	2,127	424,856	0	621,185	56.00
57.00	05700	CT SCAN	2,664	2,664	1,119,866	0	1,579,333	57.00
58.00	05800	MRI	2,050	2,050	797,206	0	1,096,954	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,678	6,678	1,297,820	0	1,911,182	59.00
60.00	06000	LABORATORY	13,472	13,472	2,539,617	0	8,758,435	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	543	543	338,262	0	1,248,694	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	313,853	0	382,006	64.00
65.00	06500	RESPIRATORY THERAPY	1,437	1,437	1,585,569	0	2,543,738	65.00
66.00	06600	PHYSICAL THERAPY	5,347	5,347	2,460,292	0	3,256,777	66.00
66.01	06601	REHAB OUTPATIENT	119	119	1,673,547	0	2,430,742	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	917,070	0	1,139,987	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	556	556	179,004	0	244,850	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	19,560,925	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,890,187	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	11,314,502	73.00
74.00	07400	RENAL DIALYSIS	0	0	716	0	872,335	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	0	15	90.01
90.02	09001	PROCEDURE CLINIC	6,372	6,372	1,851,725	0	2,556,976	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	0	198,164	0	247,807	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	399,306	0	702,234	90.05
91.00	09100	EMERGENCY	20,740	20,740	7,025,975	0	10,102,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	577,531	571,572	97,236,648	-86,055,490	207,941,521	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	2,375	98,637	0	417,282	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	119,113	0	193,200	192.00
192.01	19201	POB	0	0	0	369,502	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	171,918	0	218,543	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	11,344,335	11,586,199	14,742,372		86,055,490	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.562369	20.186880	0.151008		0.412201	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			16,377		1,991,796	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000168		0.009541	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	368,209				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,119,428			8.00
9.00	00900	HOUSEKEEPING	6,650	0	361,559		9.00
10.00	01000	DIETARY	5,912	0	5,912	63,242	10.00
11.00	01100	CAFETERIA	4,291	0	4,291	0	11.00
13.00	01300	NURSING ADMINISTRATION	9,440	0	9,440	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,975	0	2,975	0	14.00
15.00	01500	PHARMACY	4,318	0	4,318	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,605	0	6,605	0	16.00
17.00	01700	SOCIAL SERVICE	289	0	289	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	132,587	1,207,622	132,587	57,526	30.00
31.00	03100	INTENSIVE CARE UNIT	10,788	105,892	10,788	5,716	31.00
31.01	02060	NEONATAL NICU	19,663	18,158	19,663	0	31.01
43.00	04300	NURSERY	1,280	0	1,280	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	32,944	250,710	32,944	0	50.00
50.01	05001	ENDOSCOPY	10,609	0	10,609	0	50.01
51.00	05100	RECOVERY ROOM	5,664	0	5,664	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,991	135,347	14,991	0	52.00
53.00	05300	ANESTHESIOLOGY	529	0	529	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,707	5,214	14,707	0	54.00
54.01	03630	ULTRASOUND	1,122	60,400	1,122	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,030	0	1,030	0	54.02
54.03	03440	MAMMOGRAPHY	4,907	0	4,907	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	12,428	16,112	12,428	0	55.00
56.00	05600	RADIOISOTOPE	2,127	0	2,127	0	56.00
57.00	05700	CT SCAN	2,664	74,137	2,664	0	57.00
58.00	05800	MRI	2,050	0	2,050	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,678	0	6,678	0	59.00
60.00	06000	LABORATORY	13,472	0	13,472	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	543	0	543	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,437	0	1,437	0	65.00
66.00	06600	PHYSICAL THERAPY	5,347	0	5,347	0	66.00
66.01	06601	REHAB OUTPATIENT	119	0	119	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	556	0	556	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	0	90.01
90.02	09001	PROCEDURE CLINIC	6,372	0	6,372	0	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	90.05
91.00	09100	EMERGENCY	20,740	245,836	20,740	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	365,834	2,119,428	359,184	63,242	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,375	0	2,375	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	POB	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.02
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DA YS)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	19,658,380	902,388	7,556,458	5,651,203	2,116,181	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.389189	0.425770	20.899654	89.358385	16.864419	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,419,990	6,097	428,935	380,313	262,619	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	17.435723	0.002877	1.186349	6.013614	2.092882	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description			NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	86,101					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,481,657				14.00
15.00	01500	PHARMACY	0	0	11,314,502			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,549,872,396		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	77,785	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,797	0	0	182,495,027	58,764	30.00
31.00	03100	INTENSIVE CARE UNIT	5,617	0	0	22,155,865	4,578	31.00
31.01	02060	NEONATAL NICU	7,820	0	0	52,695,041	7,648	31.01
43.00	04300	NURSERY	1,011	0	0	11,000,528	6,795	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,979	0	0	137,208,327	0	50.00
50.01	05001	ENDOSCOPY	1,361	0	0	36,782,703	0	50.01
51.00	05100	RECOVERY ROOM	1,207	0	0	21,179,855	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,210	0	0	24,890,087	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	35,241,143	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,603,317	0	54.00
54.01	03630	ULTRASOUND	0	0	0	34,387,766	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	10,549,163	0	54.02
54.03	03440	MAMMOGRAPHY	0	0	0	18,377,670	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	26,012,187	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	25,742,765	0	56.00
57.00	05700	CT SCAN	0	0	0	95,428,315	0	57.00
58.00	05800	MRI	0	0	0	45,628,227	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	30,443,369	0	59.00
60.00	06000	LABORATORY	0	0	0	175,656,411	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,741,810	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,829,035	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	34,039,043	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,996,226	0	66.00
66.01	06601	REHAB OUTPATIENT	0	0	0	12,835,375	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,441,409	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,279,580	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	19,591,472	0	66,772,984	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,890,185	0	26,184,198	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	11,314,502	138,995,004	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,316,683	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	68,079	0	90.01
90.02	09001	PROCEDURE CLINIC	2,077	0	0	11,583,492	0	90.02
90.04	09002	EPILEPSY MONITORING UNIT	250	0	0	920,477	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	11,442,920	0	90.05
91.00	09100	EMERGENCY	9,772	0	0	133,948,315	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	86,101	30,481,657	11,314,502	1,549,872,396	77,785	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	POB	0	0	0	0	0	192.01
194.00	07950	COMMUNITY PROGRAMS	0	0	0	0	0	194.00
194.01	07951	RETAIL PHARMACY	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet B-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (TOTAL PATI ENT DAYS)	
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	4,521,079	1,266,852	7,734,817	3,067,019	4,242,942	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	52.509018	0.041561	0.683620	0.001979	54.547046	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	580,224	182,849	311,301	408,047	51,377	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	6.738876	0.005999	0.027513	0.000263	0.660500	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Worksheet C
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

MCRIF32 - 14.7.166.2

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	152,555,052		152,555,052		30.00
31.00	03100	INTENSIVE CARE UNIT	22,155,865		22,155,865		31.00
31.01	02060	NEONATAL NICU	52,695,041		52,695,041		31.01
43.00	04300	NURSERY	11,000,528		11,000,528		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	58,246,249	78,962,078	137,208,327	0.116119	50.00
50.01	05001	ENDOSCOPY	10,026,914	26,755,789	36,782,703	0.095225	50.01
51.00	05100	RECOVERY ROOM	9,034,488	12,145,367	21,179,855	0.129805	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,221,215	668,872	24,890,087	0.408025	52.00
53.00	05300	ANESTHESIOLOGY	14,112,877	21,128,266	35,241,143	0.013430	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,021,067	29,582,250	43,603,317	0.133838	54.00
54.01	03630	ULTRASOUND	7,908,057	26,479,709	34,387,766	0.067251	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	5,540,801	5,008,362	10,549,163	0.115673	54.02
54.03	03440	MAMMOGRAPHY	9,928	18,367,742	18,377,670	0.161070	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	839,653	25,172,534	26,012,187	0.106220	55.00
56.00	05600	RADIOISOTOPE	6,800,052	18,942,713	25,742,765	0.042481	56.00
57.00	05700	CT SCAN	26,913,809	68,514,506	95,428,315	0.027983	57.00
58.00	05800	MRI	10,209,324	35,418,903	45,628,227	0.039614	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,085,439	13,357,930	30,443,369	0.107569	59.00
60.00	06000	LABORATORY	84,638,641	91,017,770	175,656,411	0.078558	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,790,066	1,951,744	7,741,810	0.236001	63.00
64.00	06400	INTRAVENOUS THERAPY	3,412,751	416,284	3,829,035	0.144418	64.00
65.00	06500	RESPIRATORY THERAPY	30,134,743	3,904,300	34,039,043	0.111706	65.00
66.00	06600	PHYSICAL THERAPY	19,818,828	1,177,398	20,996,226	0.241978	66.00
66.01	06601	REHAB OUTPATIENT	5,242	12,830,133	12,835,375	0.272913	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	18,131,962	23,309,447	41,441,409	0.041364	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	657,006	4,622,574	5,279,580	0.076375	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,110,075	27,662,909	66,772,984	0.427873	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,437,227	7,746,971	26,184,198	0.606609	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85,113,515	53,881,489	138,995,004	0.172583	73.00
74.00	07400	RENAL DIALYSIS	4,169,270	147,413	4,316,683	0.287363	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	1,052	67,027	68,079	0.002291	90.01
90.02	09001	PROCEDURE CLINIC	145,854	11,437,638	11,583,492	0.367018	90.02
90.04	09002	EPILEPSY MONITORING UNIT	10,398	910,079	920,477	0.401007	90.04
90.05	09003	OFFSITE IMAGING CENTER	33,973	11,408,947	11,442,920	0.089475	90.05
91.00	09100	EMERGENCY	31,449,776	102,498,539	133,948,315	0.125829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,284,631	21,655,344	29,939,975	0.445908	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	792,721,369	757,151,027	1,549,872,396		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	792,721,369	757,151,027	1,549,872,396		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02060	NEONATAL NICU			31.01
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.116119		50.00
50.01	05001	ENDOSCOPY	0.095225		50.01
51.00	05100	RECOVERY ROOM	0.129805		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.408025		52.00
53.00	05300	ANESTHESIOLOGY	0.013430		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133838		54.00
54.01	03630	ULTRASOUND	0.067251		54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.115673		54.02
54.03	03440	MAMMOGRAPHY	0.161070		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.106220		55.00
56.00	05600	RADIOISOTOPE	0.042481		56.00
57.00	05700	CT SCAN	0.027983		57.00
58.00	05800	MRI	0.039614		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107569		59.00
60.00	06000	LABORATORY	0.078558		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.236001		63.00
64.00	06400	INTRAVENOUS THERAPY	0.144418		64.00
65.00	06500	RESPIRATORY THERAPY	0.111706		65.00
66.00	06600	PHYSICAL THERAPY	0.241978		66.00
66.01	06601	REHAB OUTPATIENT	0.272913		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.041364		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076375		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427873		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.606609		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172583		73.00
74.00	07400	RENAL DIALYSIS	0.287363		74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0.002291		90.01
90.02	09001	PROCEDURE CLINIC	0.367018		90.02
90.04	09002	EPILEPSY MONITORING UNIT	0.401007		90.04
90.05	09003	OFFSITE IMAGING CENTER	0.089475		90.05
91.00	09100	EMERGENCY	0.125829		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.445908		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

			Title XIX		Hospital		11/29/2016 8:07 pm	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance		Total Costs
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	84,054,153		84,054,153	0	84,054,153	30.00
31.00	03100	INTENSIVE CARE UNIT	11,267,955		11,267,955	0	11,267,955	31.00
31.01	02060	NEONATAL NICU	16,460,356		16,460,356	0	16,460,356	31.01
43.00	04300	NURSERY	2,060,823		2,060,823	0	2,060,823	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,932,524		15,932,524	0	15,932,524	50.00
50.01	05001	ENDOSCOPY	3,502,648		3,502,648	0	3,502,648	50.01
51.00	05100	RECOVERY ROOM	2,749,243		2,749,243	0	2,749,243	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,155,773		10,155,773	0	10,155,773	52.00
53.00	05300	ANESTHESIOLOGY	473,301		473,301	0	473,301	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,835,774		5,835,774	0	5,835,774	54.00
54.01	03630	ULTRASOUND	2,312,614		2,312,614	0	2,312,614	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	1,220,251		1,220,251	0	1,220,251	54.02
54.03	03440	MAMMOGRAPHY	2,960,097		2,960,097	0	2,960,097	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	2,763,010		2,763,010	0	2,763,010	55.00
56.00	05600	RADIOISOTOPE	1,093,566		1,093,566	0	1,093,566	56.00
57.00	05700	CT SCAN	2,670,348		2,670,348	0	2,670,348	57.00
58.00	05800	MRI	1,807,529		1,807,529	0	1,807,529	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,274,749		3,274,749	0	3,274,749	59.00
60.00	06000	LABORATORY	13,799,159		13,799,159	0	13,799,159	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,827,078		1,827,078	0	1,827,078	63.00
64.00	06400	INTRAVENOUS THERAPY	552,983		552,983	0	552,983	64.00
65.00	06500	RESPIRATORY THERAPY	3,802,374	0	3,802,374	0	3,802,374	65.00
66.00	06600	PHYSICAL THERAPY	5,080,631	0	5,080,631	0	5,080,631	66.00
66.01	06601	REHAB OUTPATIENT	3,502,943	0	3,502,943	0	3,502,943	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,714,182		1,714,182	0	1,714,182	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	403,229		403,229	0	403,229	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,570,347		28,570,347	0	28,570,347	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,883,559		15,883,559	0	15,883,559	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,988,239		23,988,239	0	23,988,239	73.00
74.00	07400	RENAL DIALYSIS	1,240,455		1,240,455	0	1,240,455	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	156		156	0	156	90.01
90.02	09001	PROCEDURE CLINIC	4,251,345		4,251,345	0	4,251,345	90.02
90.04	09002	EPILEPSY MONITORING UNIT	369,118		369,118	0	369,118	90.04
90.05	09003	OFFSITE IMAGING CENTER	1,023,854		1,023,854	0	1,023,854	90.05
91.00	09100	EMERGENCY	16,854,635		16,854,635	0	16,854,635	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,350,485		13,350,485		13,350,485	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	306,809,486	0	306,809,486	0	306,809,486	200.00
201.00		Less Observation Beds	13,350,485		13,350,485		13,350,485	201.00
202.00		Total (see instructions)	293,459,001	0	293,459,001	0	293,459,001	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet C
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	152,555,052		152,555,052			30.00	
31.00	03100	INTENSIVE CARE UNIT	22,155,865		22,155,865			31.00	
31.01	02060	NEONATAL NICU	52,695,041		52,695,041			31.01	
43.00	04300	NURSERY	11,000,528		11,000,528			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	58,246,249	78,962,078	137,208,327	0.116119	0.000000	50.00	
50.01	05001	ENDOSCOPY	10,026,914	26,755,789	36,782,703	0.095225	0.000000	50.01	
51.00	05100	RECOVERY ROOM	9,034,488	12,145,367	21,179,855	0.129805	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,221,215	668,872	24,890,087	0.408025	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	14,112,877	21,128,266	35,241,143	0.013430	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,021,067	29,582,250	43,603,317	0.133838	0.000000	54.00	
54.01	03630	ULTRASOUND	7,908,057	26,479,709	34,387,766	0.067251	0.000000	54.01	
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	5,540,801	5,008,362	10,549,163	0.115673	0.000000	54.02	
54.03	03440	MAMMOGRAPHY	9,928	18,367,742	18,377,670	0.161070	0.000000	54.03	
55.00	05500	RADIOLOGY-THERAPEUTIC	839,653	25,172,534	26,012,187	0.106220	0.000000	55.00	
56.00	05600	RADIOISOTOPE	6,800,052	18,942,713	25,742,765	0.042481	0.000000	56.00	
57.00	05700	CT SCAN	26,913,809	68,514,506	95,428,315	0.027983	0.000000	57.00	
58.00	05800	MRI	10,209,324	35,418,903	45,628,227	0.039614	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	17,085,439	13,357,930	30,443,369	0.107569	0.000000	59.00	
60.00	06000	LABORATORY	84,638,641	91,017,770	175,656,411	0.078558	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,790,066	1,951,744	7,741,810	0.236001	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	3,412,751	416,284	3,829,035	0.144418	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	30,134,743	3,904,300	34,039,043	0.111706	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	19,818,828	1,177,398	20,996,226	0.241978	0.000000	66.00	
66.01	06601	REHAB OUTPATIENT	5,242	12,830,133	12,835,375	0.272913	0.000000	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	18,131,962	23,309,447	41,441,409	0.041364	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	657,006	4,622,574	5,279,580	0.076375	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,110,075	27,662,909	66,772,984	0.427873	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,437,227	7,746,971	26,184,198	0.606609	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	85,113,515	53,881,489	138,995,004	0.172583	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	4,169,270	147,413	4,316,683	0.287363	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	1,052	67,027	68,079	0.002291	0.000000	90.01	
90.02	09001	PROCEDURE CLINIC	145,854	11,437,638	11,583,492	0.367018	0.000000	90.02	
90.04	09002	EPILEPSY MONITORING UNIT	10,398	910,079	920,477	0.401007	0.000000	90.04	
90.05	09003	OFFSITE IMAGING CENTER	33,973	11,408,947	11,442,920	0.089475	0.000000	90.05	
91.00	09100	EMERGENCY	31,449,776	102,498,539	133,948,315	0.125829	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,284,631	21,655,344	29,939,975	0.445908	0.000000	92.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	792,721,369	757,151,027	1,549,872,396			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	792,721,369	757,151,027	1,549,872,396			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/29/2018 8:07 pm
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
31.01	02060	NEONATAL NICU			31.01
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
50.01	05001	ENDOSCOPY	0.000000		50.01
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRASOUND	0.000000		54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.000000		54.02
54.03	03440	MAMMOGRAPHY	0.000000		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		55.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	REHAB OUTPATIENT	0.000000		66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0.000000		90.01
90.02	09001	PROCEDURE CLINIC	0.000000		90.02
90.04	09002	EPILEPSY MONITORING UNIT	0.000000		90.04
90.05	09003	OFFSITE IMAGING CENTER	0.000000		90.05
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet D
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	8,994,547	0	8,994,547	69,860	128.75	30.00
31.00	INTENSIVE CARE UNIT	785,987		785,987	4,578	171.69	31.00
31.01	NEONATAL NICU	1,331,034		1,331,034	7,648	174.04	31.01
43.00	NURSERY	101,320		101,320	6,795	14.91	43.00
200.00	Total (lines 30 through 199)	11,212,888		11,212,888	88,881		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	21,545	2,773,919				
31.00	INTENSIVE CARE UNIT	1,876	322,090				
31.01	NEONATAL NICU	0	0				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	23,421	3,096,009				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet D
Part II
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description			Title XVIII		Hospital	PPS		
			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,107,629	137,208,327	0.015361	21,064,280	323,568	50.00
50.01	05001	ENDOSCOPY	658,346	36,782,703	0.017898	4,328,145	77,465	50.01
51.00	05100	RECOVERY ROOM	361,906	21,179,855	0.017087	2,996,682	51,204	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	986,629	24,890,087	0.039639	30,426	1,206	52.00
53.00	05300	ANESTHESIOLOGY	43,106	35,241,143	0.001223	4,043,121	4,945	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	907,953	43,603,317	0.020823	6,011,940	125,187	54.00
54.01	03630	ULTRASOUND	91,794	34,387,766	0.002669	3,203,803	8,551	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	71,853	10,549,163	0.006811	2,403,766	16,372	54.02
54.03	03440	MAMMOGRAPHY	311,725	18,377,670	0.016962	1,533	26	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	745,751	26,012,187	0.028669	269,540	7,727	55.00
56.00	05600	RADIOISOTOPE	137,838	25,742,765	0.005354	3,222,713	17,254	56.00
57.00	05700	CT SCAN	198,759	95,428,315	0.002083	11,106,138	23,134	57.00
58.00	05800	MRI	144,224	45,628,227	0.003161	3,673,484	11,612	58.00
59.00	05900	CARDIAC CATHETERIZATION	418,675	30,443,369	0.013753	7,545,948	103,779	59.00
60.00	06000	LABORATORY	926,749	175,656,411	0.005276	30,578,864	161,334	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	46,696	7,741,810	0.006032	1,306,996	7,884	63.00
64.00	06400	INTRAVENOUS THERAPY	5,442	3,829,035	0.001421	1,981,638	2,816	64.00
65.00	06500	RESPIRATORY THERAPY	121,834	34,039,043	0.003579	13,571,597	48,573	65.00
66.00	06600	PHYSICAL THERAPY	354,410	20,996,226	0.016880	10,339,201	174,526	66.00
66.01	06601	REHAB OUTPATIENT	38,263	12,835,375	0.002981	966	3	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,695	41,441,409	0.000596	8,090,163	4,822	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,917	5,279,580	0.006992	219,792	1,537	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	321,711	66,772,984	0.004818	13,867,869	66,815	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	176,119	26,184,198	0.006726	8,150,640	54,821	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	455,809	138,995,004	0.003279	29,637,759	97,182	73.00
74.00	07400	RENAL DIALYSIS	9,458	4,316,683	0.002191	2,250,876	4,932	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	18	68,079	0.000264	608	0	90.01
90.02	09001	PROCEDURE CLINIC	418,038	11,583,492	0.036089	49,058	1,770	90.02
90.04	09002	EPILEPSY MONITORING UNIT	4,847	920,477	0.005266	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	10,956	11,442,920	0.000957	25,334	24	90.05
91.00	09100	EMERGENCY	1,430,425	133,948,315	0.010679	11,429,104	122,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,428,622	29,939,975	0.047716	0	0	92.00
200.00		Total (lines 50 through 199)	12,997,197	1,311,465,910		201,401,984	1,521,120	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0290		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/29/2018 8:07 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0	0	0	0	31.00
31.01	02060	NEONATAL NICU		0	0	0	0	0	0	31.01
43.00	04300	NURSERY		0	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	69,860	0.00	21,545	30.00	
31.00	03100	INTENSIVE CARE UNIT			0	4,578	0.00	1,876	31.00	
31.01	02060	NEONATAL NICU			0	7,648	0.00	0	31.01	
43.00	04300	NURSERY			0	6,795	0.00	0	43.00	
200.00		Total (lines 30 through 199)			0	88,881		23,421	200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0						30.00
31.00	03100	INTENSIVE CARE UNIT		0						31.00
31.01	02060	NEONATAL NICU		0						31.01
43.00	04300	NURSERY		0						43.00
200.00		Total (lines 30 through 199)		0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet D
Part IV
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
50.01	05001	ENDOSCOPY	0	0	0	0	50.01
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03630	ULTRASOUND	0	0	0	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	0	54.02
54.03	03440	MAMMOGRAPHY	0	0	0	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
66.01	06601	REHAB OUTPATIENT	0	0	0	0	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	0	90.01
90.02	09001	PROCEDURE CLINIC	0	0	0	0	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	0	90.05
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet D
Part IV
Date/Time Prepared:
11/29/2018 8:07 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	137,208,327	0.000000	50.00
50.01	05001	ENDOSCOPY	0	0	0	36,782,703	0.000000	50.01
51.00	05100	RECOVERY ROOM	0	0	0	21,179,855	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	24,890,087	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	35,241,143	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	43,603,317	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	34,387,766	0.000000	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0	0	10,549,163	0.000000	54.02
54.03	03440	MAMMOGRAPHY	0	0	0	18,377,670	0.000000	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	26,012,187	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	25,742,765	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	95,428,315	0.000000	57.00
58.00	05800	MRI	0	0	0	45,628,227	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	30,443,369	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	175,656,411	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,741,810	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,829,035	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	34,039,043	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	20,996,226	0.000000	66.00
66.01	06601	REHAB OUTPATIENT	0	0	0	12,835,375	0.000000	66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,441,409	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,279,580	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	66,772,984	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	26,184,198	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	138,995,004	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,316,683	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0	0	68,079	0.000000	90.01
90.02	09001	PROCEDURE CLINIC	0	0	0	11,583,492	0.000000	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	0	0	920,477	0.000000	90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0	0	11,442,920	0.000000	90.05
91.00	09100	EMERGENCY	0	0	0	133,948,315	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	29,939,975	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	1,311,465,910		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0290		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part IV Date/Time Prepared: 11/29/2018 8:07 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	21,064,280	0	12,115,190	0	50.00
50.01	05001	ENDOSCOPY		0.000000	4,328,145	0	7,738,121	0	50.01
51.00	05100	RECOVERY ROOM		0.000000	2,996,682	0	1,454,105	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	30,426	0	618	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	4,043,121	0	3,488,751	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	6,011,940	0	5,843,733	0	54.00
54.01	03630	ULTRASOUND		0.000000	3,203,803	0	4,097,013	0	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES		0.000000	2,403,766	0	2,183,416	0	54.02
54.03	03440	MAMMOGRAPHY		0.000000	1,533	0	1,352,118	0	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	269,540	0	8,207,983	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	3,222,713	0	7,676,911	0	56.00
57.00	05700	CT SCAN		0.000000	11,106,138	0	15,725,916	0	57.00
58.00	05800	MRI		0.000000	3,673,484	0	9,136,040	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	7,545,948	0	5,733,903	0	59.00
60.00	06000	LABORATORY		0.000000	30,578,864	0	9,608,469	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	1,306,996	0	639,104	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	1,981,638	0	147,482	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	13,571,597	0	1,121,542	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	10,339,201	0	34,400	0	66.00
66.01	06601	REHAB OUTPATIENT		0.000000	966	0	258,619	0	66.01
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	8,090,163	0	5,941,049	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	219,792	0	1,169,529	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	13,867,869	0	5,556,720	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	8,150,640	0	2,398,298	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	29,637,759	0	14,686,469	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	2,250,876	0	113,141	0	74.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC		0.000000	608	0	34,877	0	90.01
90.02	09001	PROCEDURE CLINIC		0.000000	49,058	0	3,645,521	0	90.02
90.04	09002	EPILEPSY MONITORING UNIT		0.000000	0	0	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER		0.000000	25,334	0	2,930,103	0	90.05
91.00	09100	EMERGENCY		0.000000	11,429,104	0	12,604,152	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	4,366,630	0	92.00
200.00		Total (lines 50 through 199)			201,401,984	0	150,009,923	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet D
Part V
Date/Time Prepared:
11/29/2018 8:07 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.116119	12,115,190	0	0	1,406,804	50.00	
50.01	05001	ENDOSCOPY	0.095225	7,738,121	0	0	736,863	50.01	
51.00	05100	RECOVERY ROOM	0.129805	1,454,105	0	0	188,750	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.408025	618	0	0	252	52.00	
53.00	05300	ANESTHESIOLOGY	0.013430	3,488,751	0	0	46,854	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133838	5,843,733	0	0	782,114	54.00	
54.01	03630	ULTRASOUND	0.067251	4,097,013	0	0	275,528	54.01	
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.115673	2,183,416	0	0	252,562	54.02	
54.03	03440	MAMMOGRAPHY	0.161070	1,352,118	0	0	217,786	54.03	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.106220	8,207,983	0	0	871,852	55.00	
56.00	05600	RADIOISOTOPE	0.042481	7,676,911	0	0	326,123	56.00	
57.00	05700	CT SCAN	0.027983	15,725,916	0	0	440,058	57.00	
58.00	05800	MRI	0.039614	9,136,040	0	0	361,915	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.107569	5,733,903	0	0	616,790	59.00	
60.00	06000	LABORATORY	0.078558	9,608,469	0	0	754,822	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.236001	639,104	0	0	150,829	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.144418	147,482	0	0	21,299	64.00	
65.00	06500	RESPIRATORY THERAPY	0.111706	1,121,542	0	0	125,283	65.00	
66.00	06600	PHYSICAL THERAPY	0.241978	34,400	0	0	8,324	66.00	
66.01	06601	REHAB OUTPATIENT	0.272913	258,619	0	0	70,580	66.01	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.041364	5,941,049	0	0	245,746	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076375	1,169,529	0	0	89,323	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427873	5,556,720	0	0	2,377,570	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.606609	2,398,298	56	0	1,454,829	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172583	14,686,469	141	63,026	2,534,635	73.00	
74.00	07400	RENAL DIALYSIS	0.287363	113,141	0	0	32,513	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0.002291	34,877	0	0	80	90.01	
90.02	09001	PROCEDURE CLINIC	0.367018	3,645,521	0	0	1,337,972	90.02	
90.04	09002	EPILEPSY MONITORING UNIT	0.401007	0	0	0	0	90.04	
90.05	09003	OFFSITE IMAGING CENTER	0.089475	2,930,103	0	0	262,171	90.05	
91.00	09100	EMERGENCY	0.125829	12,604,152	31,912	0	1,585,968	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.445908	4,366,630	0	0	1,947,115	92.00	
200.00		Subtotal (see instructions)		150,009,923	32,109	63,026	19,523,310	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00	
202.00		Net Charges (line 200 - line 201)		150,009,923	32,109	63,026	19,523,310	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0290		Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/29/2018 8:07 pm
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
50.01	05001	ENDOSCOPY	0	0		50.01
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRASOUND	0	0		54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0	0		54.02
54.03	03440	MAMMOGRAPHY	0	0		54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
66.01	06601	REHAB OUTPATIENT	0	0		66.01
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	34	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24	10,877		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0	0		90.01
90.02	09001	PROCEDURE CLINIC	0	0		90.02
90.04	09002	EPILEPSY MONITORING UNIT	0	0		90.04
90.05	09003	OFFSITE IMAGING CENTER	0	0		90.05
91.00	09100	EMERGENCY	4,015	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	4,073	10,877		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,073	10,877		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/29/2018 8:07 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		69,860	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		69,860	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		58,764	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		21,545	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		84,054,153	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		84,054,153	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		84,054,153	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,203.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		25,922,513	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		25,922,513	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet D-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	11,267,955	4,578	2,461.33	1,876	4,617,455
43.01	NEONATAL NICU	16,460,356	7,648	2,152.24	0	0
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				31,510,288	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				62,050,256	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				3,096,009	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				1,521,120	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				4,617,129	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				57,433,127	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges				0	54.00
55.00	Target amount per discharge				0.00	55.00
56.00	Target amount (line 54 x line 55)				0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0	57.00
58.00	Bonus payment (see instructions)				0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0	61.00
62.00	Relief payment (see instructions)				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)				11,096	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				1,203.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				13,350,485	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet D-1

Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	8,994,547	84,054,153	0.107009	13,350,485	1,428,622
91.00	Nursing School cost	0	84,054,153	0.000000	13,350,485	0
92.00	Allied health cost	0	84,054,153	0.000000	13,350,485	0
93.00	All other Medical Education	0	84,054,153	0.000000	13,350,485	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/29/2018 8:07 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		58,687,748		30.00
31.00	03100	INTENSIVE CARE UNIT		9,597,574		31.00
31.01	02060	NEONATAL NICU		0		31.01
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.116119	21,064,280	2,445,963	50.00
50.01	05001	ENDOSCOPY	0.095225	4,328,145	412,148	50.01
51.00	05100	RECOVERY ROOM	0.129805	2,996,682	388,984	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.408025	30,426	12,415	52.00
53.00	05300	ANESTHESIOLOGY	0.013430	4,043,121	54,299	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.133838	6,011,940	804,626	54.00
54.01	03630	ULTRASOUND	0.067251	3,203,803	215,459	54.01
54.02	05401	RADIOLOGY-SPECIAL PROCEDURES	0.115673	2,403,766	278,051	54.02
54.03	03440	MAMMOGRAPHY	0.161070	1,533	247	54.03
55.00	05500	RADIOLOGY-THERAPEUTIC	0.106220	269,540	28,631	55.00
56.00	05600	RADIOISOTOPE	0.042481	3,222,713	136,904	56.00
57.00	05700	CT SCAN	0.027983	11,106,138	310,783	57.00
58.00	05800	MRI	0.039614	3,673,484	145,521	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.107569	7,545,948	811,710	59.00
60.00	06000	LABORATORY	0.078558	30,578,864	2,402,214	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.236001	1,306,996	308,452	63.00
64.00	06400	INTRAVENOUS THERAPY	0.144418	1,981,638	286,184	64.00
65.00	06500	RESPIRATORY THERAPY	0.111706	13,571,597	1,516,029	65.00
66.00	06600	PHYSICAL THERAPY	0.241978	10,339,201	2,501,859	66.00
66.01	06601	REHAB OUTPATIENT	0.272913	966	264	66.01
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041364	8,090,163	334,642	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.076375	219,792	16,787	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.427873	13,867,869	5,933,687	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.606609	8,150,640	4,944,252	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172583	29,637,759	5,114,973	73.00
74.00	07400	RENAL DIALYSIS	0.287363	2,250,876	646,818	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09005	CONGESTIVE HEART FAILURE CLINIC	0.002291	608	1	90.01
90.02	09001	PROCEDURE CLINIC	0.367018	49,058	18,005	90.02
90.04	09002	EPILEPSY MONITORING UNIT	0.401007	0	0	90.04
90.05	09003	OFFSITE IMAGING CENTER	0.089475	25,334	2,267	90.05
91.00	09100	EMERGENCY	0.125829	11,429,104	1,438,113	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.445908	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		201,401,984	31,510,288	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		201,401,984		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/29/2018 8:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		9,758,209	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		30,317,791	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		1,320,417	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		287.60	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.93	30.00
31.00	Percentage of Medicaid patient days (see instructions)		26.40	31.00
32.00	Sum of lines 30 and 31		28.33	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.59	33.00
34.00	Disproportionate share adjustment (see instructions)		1,261,393	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/29/2018 8:07 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000592552	0.000464345	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		3,541,971	3,142,084	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		892,772	2,350,106	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		3,242,878		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		45,900,688		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			45,900,688	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			3,687,906	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			6,214	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			49,594,808	59.00
60.00	Primary payer payments			92,121	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			49,502,687	61.00
62.00	Deductibles billed to program beneficiaries			4,311,088	62.00
63.00	Coinsurance billed to program beneficiaries			218,312	63.00
64.00	Allowable bad debts (see instructions)			905,228	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			588,398	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			498,620	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			45,561,685	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			156,142	70.93
70.94	HRR adjustment amount (see instructions)			-726,480	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/29/2018 8:07 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		44,991,347	71.00
71.01	Sequestration adjustment (see instructions)		899,827	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		43,478,094	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		613,426	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		764,435	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/29/2018 8:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14,950	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,523,310	2.00
3.00	OPPS payments		20,031,690	3.00
4.00	Outlier payment (see instructions)		33,297	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		14,950	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		95,135	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		95,135	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		95,135	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		80,185	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		14,950	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		20,064,987	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,857,274	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		16,222,663	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		16,222,663	30.00
31.00	Primary payer payments		17,002	31.00
32.00	Subtotal (line 30 minus line 31)		16,205,661	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		792,031	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		514,820	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		451,358	36.00
37.00	Subtotal (see instructions)		16,720,481	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		16,720,481	40.00
40.01	Sequestration adjustment (see instructions)		334,410	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		16,218,197	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		167,874	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet E-1
Part I
Date/Time Prepared:
11/29/2018 8:07 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		43,131,296		15,875,508	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		346,798		342,689	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		43,478,094		16,218,197	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		613,426		167,874	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		44,091,520		16,386,071	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet E-1
Part II
Date/Time Prepared:
11/29/2018 8:07 pm

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

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

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet G

Date/Time Prepared:
11/29/2018 8:07 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	13,598	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	56,200,385	0	0	0	4.00
5.00	Other receivable	2,666,013	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	5,485,212	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	86,794,753	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	151,159,961	0	0	0	11.00
FIXED ASSETS						
12.00	Land	12,412,466	0	0	0	12.00
13.00	Land improvements	263,919,802	0	0	0	13.00
14.00	Accumulated depreciation	-91,525,367	0	0	0	14.00
15.00	Buildings	0	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	56,793,803	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	241,600,704	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,258,996	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	433,433	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,692,429	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	394,453,094	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,852,079	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,728,008	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	89,980,072	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	107,560,159	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	107,560,159	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	286,892,935				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	286,892,935	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	394,453,094	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet G-1

Date/Time Prepared:
11/29/2018 8:07 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		220,247,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		36,957,715				2.00
3.00	Total (sum of line 1 and line 2)		257,204,715		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	TRANSFERS FROM AFFILIATES	29,688,220		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		29,688,220		0		10.00
11.00	Subtotal (line 3 plus line 10)		286,892,935		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		286,892,935		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	TRANSFERS FROM AFFILIATES		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2018 8:07 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	160,370,679		160,370,679	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	160,370,679		160,370,679	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	22,189,822		22,189,822	11.00
11.01	NEONATAL NICU	56,771,951		56,771,951	11.01
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	78,961,773		78,961,773	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	239,332,452		239,332,452	17.00
18.00	Ancillary services	542,697,908	762,048,624	1,304,746,532	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	11,000,632	0	11,000,632	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	793,030,992	762,048,624	1,555,079,616	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		316,230,921		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		316,230,921		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0290

Period:
From 07/01/2017
To 06/30/2018

Worksheet G-3

Date/Time Prepared:
11/29/2018 8:07 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,555,079,616	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,208,891,577	2.00
3.00	Net patient revenues (line 1 minus line 2)	346,188,039	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	316,230,921	4.00
5.00	Net income from service to patients (line 3 minus line 4)	29,957,118	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,710,740	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	1,384,873	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	393,318	20.00
21.00	Rental of vending machines	92,698	21.00
22.00	Rental of hospital space	1,554,395	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	1,226,760	24.00
24.01	CAPITATION	561,807	24.01
24.02	GROUND LEASE	76,006	24.02
24.03	OTHER (SPECIFY)	0	24.03
24.04	OTHER (SPECIFY)	0	24.04
24.05	OTHER (SPECIFY)	0	24.05
25.00	Total other income (sum of lines 6-24)	7,000,597	25.00
26.00	Total (line 5 plus line 25)	36,957,715	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	36,957,715	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0290	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/29/2018 8:07 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		3,259,067	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		236,228	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		194.50	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		1.93	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		26.40	8.00
9.00	Sum of lines 7 and 8		28.33	9.00
10.00	Allowable disproportionate share percentage (see instructions)		5.91	10.00
11.00	Disproportionate share adjustment (see instructions)		192,611	11.00
12.00	Total prospective capital payments (see instructions)		3,687,906	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00