

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: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/28/2017 12:24 pm
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/28/2017 Time: 12:24 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 HOLY CROSS HOSPITAL (14-0133) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	471,164	-85,953	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-54,333	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	416,831	-85,953	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: 14-0133		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 11:20 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60629 County: COOK				
1.00 Street: 2701 WEST 68TH STREET		2.00 City: CHICAGO								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	HOLY CROSS HOSPITAL	140133	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	REHAB UNIT	14T133	16974	5	07/01/2000	N	P	P	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
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
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)					07/01/2016	06/30/2017		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)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						1	N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,021	523	5	41	13,212	981		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	69	36	0	0	1,029			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 11:20 am			
		Urban/Rural	St	Date of Geogra			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(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)(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	XVII	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 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	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under 413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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)		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			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)		0.00	0.00			61.05

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	Y/N	IME	Direct GME	IME	Direct GME				
	1.00	2.00	3.00	4.00	5.00				
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)					0.00	0.00	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 and enter in column 4, 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 and enter in column 4, direct GME FTE unweighted count.					0.00	0.00	61.20	
						1.00			
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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 64-67. (see instructions)					N	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
	1.00	2.00	3.00	4.00	5.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00
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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				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 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	0	76.00
				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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? 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

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		V		XIX			
		1.00		2.00			
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	
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (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. 11.					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.	N	N	N	N	109.00	
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	110.00
						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.			0			118.00
		Premiums		Losses		Insurance	
		1.00		2.00		3.00	
118.01	List amounts of malpractice premiums and paid losses:	0		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
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 state health or similar taxes? 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 11:20 am			
		1.00	2.00				
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			140.00		
		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:	Contractor's Name:	Contractor's Number:		141.00		
142.00	Street:	PO Box:			142.00		
143.00	City:	State:	Zip Code:		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 1.00	Part B 2.00	Title V 3.00	Title XIX 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	
161.20	OPT		N	N	N	161.20	
161.30	OOT		N	N	N	161.30	
161.40	OSP		N	N	N	161.40	
				1.00			
Multi campus							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N	165.00		
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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.			N	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)				168.00		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				168.01		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00	169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/28/2017 11:20 am
			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)			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	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0133		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 11:20 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2017	Y	10/31/2017		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 11:20 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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.		N		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.	NASIM		CORY	41.00
42.00	Enter the employer/company name of the cost report preparer	HOLY CROSS HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	773-257-6206		NASIM.CORY@SINAI.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/28/2017 11:20 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, GOVT REIMB & REPORTING		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: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	196	67,722	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)		196	67,722	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		216	75,022	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	34	12,410		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.20 CMHC - OPT	99.20				0	25.20
25.30 CMHC - OOT	99.30				0	25.30
25.40 CMHC - OSP	99.40				0	25.40
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)		250				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	11,688	2,819	35,194			1.00
2.00	HMO and other (see instructions)	5,263	14,239				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	469	1,029				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	11,688	2,819	35,194			7.00
8.00	INTENSIVE CARE UNIT	1,986	327	4,551			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		386	780			13.00
14.00	Total (see instructions)	13,674	3,532	40,525	0.00	861.24	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	1,468	105	3,573	0.00	18.76	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
25.20	CMHC - OPT	0	0	0	0.00	0.00	25.20
25.30	CMHC - OOT	0	0	0	0.00	0.00	25.30
25.40	CMHC - OSP	0	0	0	0.00	0.00	25.40
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	880.00	27.00
28.00	Observation Bed Days		510	6,288			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	12	69			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	2,752	824	9,241	1.00
2.00	HMO and other (see instructions)			989	3,567		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				86		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,752	824	9,241	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	124	18	293	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
25.20	CMHC - OPT	0.00					25.20
25.30	CMHC - OOT	0.00					25.30
25.40	CMHC - OSP	0.00					25.40
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						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2017 11:20 am

	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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 II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	54,698,226	3,353,990	58,052,216	1,886,657.00	30.77
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)		1,276,866	0	1,276,866	44,624.00	28.61
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		1,109,374	0	1,109,374	15,778.00	70.31
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		176,285	0	176,285	2,181.00	80.83
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		0	0	0	0.00	0.00
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)		9,222,449	0	9,222,449		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		216,975	0	216,975		
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		0	0	0		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	10,143	606,423	616,566	20,302.00	30.37
27.00	Administrative & General	5.00	3,807,727	2,747,027	6,554,754	171,327.00	38.26
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2017 11:20 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati 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		
30.00	Operation of Plant	7.00	2,423,531	0	2,423,531	117,299.00	20.66	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,087,984	0	1,087,984	81,285.00	13.38	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	973,566	-400,702	572,864	41,991.00	13.64	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	400,702	400,702	29,372.00	13.64	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,433,384	-443,621	989,763	17,161.00	57.68	38.00
39.00	Central Services and Supply	14.00	191,557	0	191,557	12,188.00	15.72	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,381,730	0	1,381,730	47,308.00	29.21	41.00
42.00	Social Service	17.00	1,167,723	0	1,167,723	35,365.00	33.02	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part III Date/Time Prepared: 11/28/2017 11:20 am
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	Worksheet A Line Number	Amount Reported	Reclassifi- cation 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)	54,698,226	3,353,990	58,052,216	1,886,657.00	30.77	1.00
2.00	Excluded area salaries (see instructions)	1,276,866	0	1,276,866	44,624.00	28.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	53,421,360	3,353,990	56,775,350	1,842,033.00	30.82	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,285,659	0	1,285,659	17,959.00	71.59	4.00
5.00	Subtotal wage-related costs (see inst.)	9,222,449	0	9,222,449	0.00	16.24	5.00
6.00	Total (sum of lines 3 thru 5)	63,929,468	3,353,990	67,283,458	1,859,992.00	36.17	6.00
7.00	Total overhead cost (see instructions)	12,477,345	2,909,829	15,387,174	573,598.00	26.83	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2017 11:20 am
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	489,000	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	3,382,470	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)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	599,277	9.00
10.00	Dental, Hearing and Vision Plan	53,519	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	182,431	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)	170,915	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	552,280	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	3,973,166	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	29,292	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	7,074	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,439,424	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: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part V Date/Time Prepared: 11/28/2017 11:20 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,109,374	9,439,424	1.00
2.00	Hospital	1,109,374	9,439,424	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/28/2017 11:20 am
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			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)		0.196410	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		39,591,977	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		46,862,655	6.00	
7.00	Medicaid cost (line 1 times line 6)		9,204,294	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)		0	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)		0	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	38,009,938	0	38,009,938	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	7,465,532	0	7,465,532	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	7,465,532	0	7,465,532	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?				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)			13,317,972	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			756,785	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,164,285	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			12,153,687	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,794,606	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			10,260,138	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			10,260,138	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		3,377,724	3,377,724	566,946	3,944,670	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		5,221,500	5,221,500	0	5,221,500	2.00
3.00 00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,143	10,584,896	10,595,039	28,233	10,623,272	4.00
5.01 00540	NONPATIENT TELEPHONES	290,358	843,038	1,133,396	-220	1,133,176	5.01
5.02 00550	DATA PROCESSING	52,501	3,948,325	4,000,826	-9,843	3,990,983	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	159,146	148,309	307,455	-2,103	305,352	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	681,397	1,364,314	2,045,711	0	2,045,711	5.04
5.05 00590	OTHER ADMINISTRATIVE & GENERAL	2,624,325	13,378,205	16,002,530	58,471	16,061,001	5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	2,423,531	4,190,047	6,613,578	0	6,613,578	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	787,303	787,303	0	787,303	8.00
9.00 00900	HOUSEKEEPING	1,087,984	810,127	1,898,111	0	1,898,111	9.00
10.00 01000	DIETARY	973,566	1,283,199	2,256,765	-928,843	1,327,922	10.00
11.00 01100	CAFETERIA	0	0	0	928,843	928,843	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	1,433,384	177,334	1,610,718	-536,128	1,074,590	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	191,557	299,109	490,666	0	490,666	14.00
15.00 01500	PHARMACY	0	0	0	-14,129	-14,129	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,381,730	1,039,495	2,421,225	0	2,421,225	16.00
17.00 01700	SOCIAL SERVICE	1,167,723	17,162	1,184,885	0	1,184,885	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	13,621,139	2,290,697	15,911,836	-226,219	15,685,617	30.00
31.00 03100	INTENSIVE CARE UNIT	3,479,978	1,060,551	4,540,529	-278,962	4,261,567	31.00
41.00 04100	SUBPROVIDER - IIRF	1,276,866	115,962	1,392,828	-49,983	1,342,845	41.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	2,987,769	3,100,707	6,088,476	-2,327,173	3,761,303	50.00
51.00 05100	RECOVERY ROOM	361,924	22,721	384,645	-14,079	370,566	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,727,905	1,744,266	3,472,171	-81,426	3,390,745	52.00
53.00 05300	ANESTHESIOLOGY	0	1,472,052	1,472,052	0	1,472,052	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,753,800	347,005	2,100,805	-40,897	2,059,908	54.00
54.02 03630	ULTRA SOUND	693,148	58,176	751,324	-19,840	731,484	54.02
56.00 05600	RADIO SOTOPE	288,253	277,342	565,595	-2,040	563,555	56.00
57.00 05700	CT SCAN	600,960	502,226	1,103,186	-44,805	1,058,381	57.00
59.00 05900	CARDIAC CATHETERIZATION	242,216	410,288	652,504	-312,210	340,294	59.00
60.00 06000	LABORATORY	1,499,024	3,242,139	4,741,163	-9,387	4,731,776	60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	1,426,956	241,001	1,667,957	-70,630	1,597,327	65.00
66.00 06600	PHYSICAL THERAPY	810,330	17,455	827,785	-1,163	826,622	66.00
67.00 06700	OCCUPATIONAL THERAPY	598,564	19,834	618,398	-65	618,333	67.00
68.00 06800	SPEECH PATHOLOGY	237,698	72,168	309,866	-624	309,242	68.00
69.00 06900	ELECTROCARDIOLOGY	556,174	117,976	674,150	-14,894	659,256	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	60,350	3,154	63,504	-2,371	61,133	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,735,737	3,735,737	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,435,822	1,435,822	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,186,675	3,850,133	6,036,808	-11,317	6,025,491	73.00
74.00 07400	RENAL DIALYSIS	587,921	193,249	781,170	-23,883	757,287	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00 09000	CLINIC	0	0	0	0	0	90.00
91.00 09100	EMERGENCY	7,223,231	4,375,835	11,599,066	-1,089,334	10,509,732	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20 09921	OPT	0	0	0	0	0	99.20
99.30 09931	OOT	0	0	0	0	0	99.30
99.40 09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE		641,484	641,484	-641,484	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	54,698,226	71,646,508	126,344,734	0	126,344,734	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01 19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00 07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	54,698,226	71,646,508	126,344,734	0	126,344,734	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-461,576	3,483,094	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	5,221,500	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,623,272	4.00
5.01	00540	NONPATIENT TELEPHONES	0	1,133,176	5.01
5.02	00550	DATA PROCESSING	0	3,990,983	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	305,352	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,045,711	5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	-788,214	15,272,787	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-209,924	6,403,654	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	787,303	8.00
9.00	00900	HOUSEKEEPING	0	1,898,111	9.00
10.00	01000	DIETARY	-10,615	1,317,307	10.00
11.00	01100	CAFETERIA	0	928,843	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,074,590	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	490,666	14.00
15.00	01500	PHARMACY	0	-14,129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-831	2,420,394	16.00
17.00	01700	SOCIAL SERVICE	0	1,184,885	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-710,796	14,974,821	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,261,567	31.00
41.00	04100	SUBPROVIDER - IIRF	-8,709	1,334,136	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,761,303	50.00
51.00	05100	RECOVERY ROOM	0	370,566	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,529,855	1,860,890	52.00
53.00	05300	ANESTHESIOLOGY	-1,472,052	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-15,102	2,044,806	54.00
54.02	03630	ULTRA SOUND	0	731,484	54.02
56.00	05600	RADIOISOTOPE	0	563,555	56.00
57.00	05700	CT SCAN	0	1,058,381	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	340,294	59.00
60.00	06000	LABORATORY	0	4,731,776	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,597,327	65.00
66.00	06600	PHYSICAL THERAPY	0	826,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	618,333	67.00
68.00	06800	SPEECH PATHOLOGY	0	309,242	68.00
69.00	06900	ELECTROCARDIOLOGY	0	659,256	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	61,133	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,735,737	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,435,822	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-139,202	5,886,289	73.00
74.00	07400	RENAL DIALYSIS	0	757,287	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-2,142,324	8,367,408	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.20	09921	OPT	0	0	99.20
99.30	09931	OOT	0	0	99.30
99.40	09941	OSP	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,489,200	118,855,534	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-7,489,200	118,855,534	200.00

RECLASSIFICATIONS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6
Date/Time Prepared:
11/28/2017 11:20 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	400,702	0	1.00	
2.00	CAFETERIA	11.00	0	528,141	2.00	
	0		400,702	528,141		
B - BED & PT RENTAL						
1.00	ADULTS & PEDIATRICS	30.00	0	91,967	1.00	
	0		0	91,967		
C - INTEREST EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	461,576	1.00	
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	179,908	2.00	
	0		0	641,484		
D - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	105,370	1.00	
	0		0	105,370		
E - MED SUPPLY & INPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,735,737	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	
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	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,435,822	23.00	
24.00		0.00	0	0	24.00	
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	
32.00		0.00	0	0	32.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
	0		0	5,171,559		
F - SINAI HEALTH SYSTEM RECLASS						
1.00	DATA PROCESSING	5.02	1,381,427	0	1.00	
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05	1,197,948	0	2.00	
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	453,343	0	3.00	
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	117,529	0	4.00	
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	35,551	0	5.00	
6.00	NONPATIENT TELEPHONES	5.01	65,832	0	6.00	
7.00	PURCHASING RECEIVING AND STORES	5.03	101,820	0	7.00	
8.00	NURSING ADMINISTRATION	13.00	540	0	8.00	
9.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35,751	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	
	0		3,353,990	35,751		
G - DIRECTORSHIP RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	0	82,500	1.00	
	0		0	82,500		
H - NURSING ADMIN						
1.00	ADULTS & PEDIATRICS	30.00	444,161	0	1.00	
	0		444,161	0		
500.00	Grand Total: Increases		4,198,853	6,656,772	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-6
Date/Time Prepared:
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Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	400,702	0	0	1.00
2.00	DIETARY	10.00	0	528,141	0	2.00
	O		400,702	528,141		
B - BED & PT RENTAL						
1.00	NURSING ADMINISTRATION	13.00	0	91,967	0	1.00
	O		0	91,967		
C - INTEREST EXPENSE RECLASS						
1.00	INTEREST EXPENSE	113.00	0	641,484	11	1.00
2.00		0.00	0	0	0	2.00
	O		0	641,484		
D - INSURANCE RECLASS						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	105,370	11	1.00
	O		0	105,370		
E - MED SUPPLY & INPLANTABLE DEVICE						
1.00	ADULTS & PEDIATRICS	30.00	0	679,827	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	361,444	0	2.00
3.00	SUBPROVIDER - IRF	41.00	0	49,983	0	3.00
4.00	OPERATING ROOM	50.00	0	1,142,747	0	4.00
5.00	RECOVERY ROOM	51.00	0	14,079	0	5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	81,426	0	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	35,401	0	7.00
8.00	ULTRASOUND	54.02	0	19,840	0	8.00
9.00	RADIOISOTOPE	56.00	0	2,040	0	9.00
10.00	CT SCAN	57.00	0	44,067	0	10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	68,991	0	11.00
12.00	LABORATORY	60.00	0	9,050	0	12.00
13.00	RESPIRATORY THERAPY	65.00	0	70,630	0	13.00
14.00	PHYSICAL THERAPY	66.00	0	1,163	0	14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	65	0	15.00
16.00	SPEECH PATHOLOGY	68.00	0	624	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	14,446	0	17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,371	0	18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,317	0	19.00
20.00	PHARMACY	15.00	0	14,129	0	20.00
21.00	RENAL DIALYSIS	74.00	0	23,883	0	21.00
22.00	EMERGENCY	91.00	0	1,088,214	0	22.00
23.00	ADULTS & PEDIATRICS	30.00	0	20	0	23.00
24.00	INTENSIVE CARE UNIT	31.00	0	18	0	24.00
26.00	OPERATING ROOM	50.00	0	1,184,426	0	26.00
27.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,496	0	27.00
28.00	CT SCAN	57.00	0	738	0	28.00
29.00	CARDIAC CATHETERIZATION	59.00	0	243,219	0	29.00
32.00	EMERGENCY	91.00	0	1,120	0	32.00
34.00	LABORATORY	60.00	0	337	0	34.00
35.00	ELECTROCARDIOLOGY	69.00	0	448	0	35.00
	O		0	5,171,559		
F - SINAI HEALTH SYSTEM RECLASS						
1.00	DATA PROCESSING	5.02	0	1,381,427	0	1.00
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	1,197,948	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	453,343	0	3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	117,529	0	4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35,551	0	5.00
6.00	NONPATIENT TELEPHONES	5.01	0	65,832	0	6.00
7.00	PURCHASING RECEIVING AND STORES	5.03	0	101,820	0	7.00
8.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,518	0	8.00
9.00	NONPATIENT TELEPHONES	5.01	0	220	0	9.00
10.00	DATA PROCESSING	5.02	0	9,843	0	10.00
11.00	PURCHASING RECEIVING AND STORES	5.03	0	2,103	0	11.00
12.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	16,067	0	12.00
13.00	NURSING ADMINISTRATION	13.00	0	540	0	13.00
	O		0	3,389,741		
G - DIRECTORSHIP RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	82,500	0	1.00
	O		0	82,500		
H - NURSING ADMIN						
1.00	NURSING ADMINISTRATION	13.00	444,161	0	0	1.00
	O		444,161	0		
500.00	Grand Total: Decreases		844,863	10,010,762		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2017 11:20 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,700,000	0	0	0	0	1.00
2.00	Land Improvements	707,906	0	0	0	0	2.00
3.00	Buildings and Fixtures	83,549,231	12,780,939	0	12,780,939	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	28,754,040	1,680,899	0	1,680,899	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	114,711,177	14,461,838	0	14,461,838	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	114,711,177	14,461,838	0	14,461,838	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,700,000	0				1.00
2.00	Land Improvements	707,906	0				2.00
3.00	Buildings and Fixtures	96,330,170	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	30,434,939	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	129,173,015	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	129,173,015	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part II
Date/Time Prepared:
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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	3,377,724	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,221,500	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,599,224	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	3,377,724				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,221,500				2.00
3.00	Total (sum of lines 1-2)	0	8,599,224				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-7
Part III
Date/Time Prepared:
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	98,738,076	0	98,738,076	0.764386	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	30,434,939	0	30,434,939	0.235614	0	2.00
3.00	Total (sum of lines 1-2)	129,173,015	0	129,173,015	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	3,377,724	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,221,500	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,599,224	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	105,370	0	0	0	3,483,094	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,221,500	2.00
3.00	Total (sum of lines 1-2)	105,370	0	0	0	8,704,594	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8

Date/Time Prepared:
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			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	-5,178,704				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		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 GEN HOSP - OTHER MISC A8-1	B	-138	0	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.00
33.01			0		0.00	0	33.01
33.02 HIM A8-1	B	-831	0	MEDICAL RECORDS & LIBRARY	16.00	0	33.02

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	
33.03 VENDING INC A8-1	B	-10,615	DIETARY	10.00	0	33.03
33.04		0		0.00	0	33.04
33.05 PARKING INC A8-1	B	-100,677	OPERATION OF PLANT	7.00	0	33.05
33.06		0		0.00	0	33.06
33.07 340B REVENUE OTH CONTRACT A8-1	B	-137,705	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08		0		0.00	0	33.08
33.09 MARKETING OFFSET A8-3	A	-89,366	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.09
33.10 LOBBYISTS OFFSET A8-4	A	-85,020	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.10
33.11 INTEREST INCOME A8-5	A	-461,576	CAP REL COSTS-BLDG & FIXT	1.00	11	33.11
33.12 INTEREST INCOME A8-5	A	-179,909	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.12
33.13		0		0.00	0	33.13
33.14		0		0.00	0	33.14
33.15 DONATION OFFSET A8-8	A	-4,087	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.15
33.16 LOBBYING OFFSET A8-9	A	-4,895	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.16
33.17 HOSPICE OFFSET A8-10	A	-24,910	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.17
33.18 340 B REV OFFSET A8-1	B	-1,497	DRUGS CHARGED TO PATIENTS	73.00	0	33.18
33.19		0		0.00	0	33.19
33.20 OPERATION AND PLANT A8-2	B	-109,247	OPERATION OF PLANT	7.00	0	33.20
33.21		0		0.00	0	33.21
33.22 OTH MISC INC A8-2	B	-26,451	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.22
33.23 OTH MISC INC A8-2	B	-17,424	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.23
33.24 PART B OFFSET A8-13	A	-710,796	ADULTS & PEDIATRICS	30.00	0	33.24
33.25 PART B OFFSET A8-13	A	-330,250	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.25
33.26		0		0.00	0	33.26
33.27 DIAGNOSTIC RADIOLOGY A8-2	B	-15,102	RADIOLOGY-DIAGNOSTIC	54.00	0	33.27
33.28		0		0.00	0	33.28
33.29 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.29
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,489,200				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: 14-0133
 Period: From 07/01/2016 To 06/30/2017
 Worksheet A-8-1
 Date/Time Prepared: 11/28/2017 11:20 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SALARY & OTHER	1,260,168	1,260,168 1.00
2.00	5.02	DATA PROCESSING	SALARY & OTHER	3,928,644	3,928,644 2.00
3.00	60.00	LABORATORY	SALARY & OTHER	1,600,098	1,600,098 3.00
3.01	5.01	NONPATIENT TELEPHONES		420,228	420,228 3.01
3.02	5.03	PURCHASING RECEIVING AND STO		147,504	147,504 3.02
3.03	13.00	NURSING ADMINISTRATION		2,772	2,772 3.03
3.04	52.00	DELIVERY ROOM & LABOR ROOM		1,117,356	1,117,356 3.04
3.05	53.00	ANESTHESIOLOGY		1,472,052	1,472,052 3.05
3.06	91.00	EMERGENCY		2,142,324	2,142,324 3.06
4.00	5.05	OTHER ADMINISTRATIVE & GENER	SALARY & OTHER	1,677,970	1,677,970 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,769,116	13,769,116 5.00

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

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

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

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

6.00	E	SINAI HLTH SYST	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
9.01			0.00	0.00	9.01
10.00			0.00	0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:
11/28/2017 11:20 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
4.00	0	0		4.00
5.00	0	0		5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
9.01			9.01
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: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet A-8-2

Date/Time Prepared:
11/28/2017 11:20 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	INTENSIVE CARE UNIT	82,500	0	82,500	179,000	1,533	1.00
2.00	41.00	SUBPROVIDER - IRF	31,791	0	31,791	211,500	227	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	1,529,855	1,529,855	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	1,472,052	1,472,052	0	0	0	4.00
5.00	5.05	OTHER ADMINISTRATIVE & GENERAL	61,994	0	61,994	179,000	421	5.00
6.00	91.00	EMERGENCY	2,142,324	2,142,324	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			5,320,516	5,144,231	176,285		2,181	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	31.00	INTENSIVE CARE UNIT	131,926	6,596	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	23,082	1,154	0	0	0	2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	5.05	OTHER ADMINISTRATIVE & GENERAL	36,230	1,812	0	0	0	5.00
6.00	91.00	EMERGENCY	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			191,238	9,562	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	31.00	INTENSIVE CARE UNIT	0	131,926	0	0		1.00
2.00	41.00	SUBPROVIDER - IRF	0	23,082	8,709	8,709		2.00
3.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,529,855		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	1,472,052		4.00
5.00	5.05	OTHER ADMINISTRATIVE & GENERAL	0	36,230	25,764	25,764		5.00
6.00	91.00	EMERGENCY	0	0	0	2,142,324		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	191,238	34,473	5,178,704		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,483,094	3,483,094			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,221,500		5,221,500		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,623,272	30,194	646	10,654,112	4.00
5.01 00540	NONPATIENT TELEPHONES	1,133,176	3,726	105,003	66,072	1,307,977 5.01
5.02 00550	DATA PROCESSING	3,990,983	21,205	1,545,015	265,988	31,824 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	305,352	14,682	0	48,408	19,095 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,045,711	30,887	192	126,396	78,500 5.04
5.05 00590	OTHER ADMINISTRATIVE & GENERAL	15,272,787	521,962	18,462	709,016	360,673 5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	6,403,654	204,851	51,598	449,555	51,980 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	787,303	222,165	0	0	0 8.00
9.00 00900	HOUSEKEEPING	1,898,111	0	0	201,817	0 9.00
10.00 01000	DIETARY	1,317,307	137,357	23,582	106,264	24,399 10.00
11.00 01100	CAFETERIA	928,843	104,060	0	74,329	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	1,074,590	16,067	255,267	183,597	2,122 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	490,666	83,519	347,427	35,533	11,669 14.00
15.00 01500	PHARMACY	-14,129	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,420,394	32,272	4,215	256,305	86,986 16.00
17.00 01700	SOCIAL SERVICE	1,184,885	0	0	216,608	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,974,821	618,196	158,795	2,609,087	242,925 30.00
31.00 03100	INTENSIVE CARE UNIT	4,261,567	172,164	102,966	645,522	22,277 31.00
41.00 04100	SUBPROVIDER - I RF	1,334,136	93,076	19,702	236,854	32,885 41.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,761,303	216,971	349,677	554,219	94,412 50.00
51.00 05100	RECOVERY ROOM	370,566	15,222	13,577	67,135	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,860,890	136,567	201,621	320,519	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,044,806	188,992	1,067,507	325,323	97,594 54.00
54.02 03630	ULTRA SOUND	731,484	7,341	1,043	128,576	0 54.02
56.00 05600	RADIOISOTOPE	563,555	15,928	109,911	53,470	0 56.00
57.00 05700	CT SCAN	1,058,381	14,128	225,896	111,476	0 57.00
59.00 05900	CARDIAC CATHETERIZATION	340,294	0	33,167	44,930	7,426 59.00
60.00 06000	LABORATORY	4,731,776	120,501	68,775	278,063	44,554 60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	1,597,327	22,023	96,245	264,695	0 65.00
66.00 06600	PHYSICAL THERAPY	826,622	61,774	2,556	150,313	11,669 66.00
67.00 06700	OCCUPATIONAL THERAPY	618,333	26,039	0	111,031	0 67.00
68.00 06800	SPEECH PATHOLOGY	309,242	20,776	0	44,092	0 68.00
69.00 06900	ELECTROCARDIOLOGY	659,256	21,469	192,069	103,168	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	61,133	26,067	5,084	11,195	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,735,737	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,435,822	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	5,886,289	31,164	78,537	405,619	23,338 73.00
74.00 07400	RENAL DIALYSIS	757,287	0	34,031	109,057	0 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	8,367,408	198,757	108,934	1,339,880	61,527 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
99.20 09921	OPT	0	0	0	0	0 99.20
99.30 09931	OOT	0	0	0	0	0 99.30
99.40 09941	OSP	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	118,855,534	3,430,102	5,221,500	10,654,112	1,305,855 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,903	0	0	2,122 190.00
190.01 19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0 190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	SEASON HOSPICE	0	28,089	0	0	0 194.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118-201)	118,855,534	3,483,094	5,221,500	10,654,112	1,307,977	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
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
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	5,855,015					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	73,815	461,352				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,238,976	910	3,521,572			5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	1,593,908	9,540	0	18,486,348	18,486,348	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	67,355	40,237	0	7,269,230	1,338,687	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,024	50,590	0	1,073,082	197,617	8.00
9.00	00900	HOUSEKEEPING	0	584	0	2,100,512	386,826	9.00
10.00	01000	DIETARY	0	17,291	0	1,626,200	299,478	10.00
11.00	01100	CAFETERIA	0	0	0	1,107,232	203,906	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,658	4,160	0	1,540,461	283,688	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	40,539	16,829	0	1,026,182	188,980	14.00
15.00	01500	PHARMACY	0	0	0	-14,129	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	396,385	3,619	0	3,200,176	589,338	16.00
17.00	01700	SOCIAL SERVICE	0	183	0	1,401,676	258,130	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	789,325	16,591	488,039	19,897,779	3,664,288	30.00
31.00	03100	INTENSIVE CARE UNIT	165,971	6,270	129,623	5,506,360	1,014,040	31.00
41.00	04100	SUBPROVIDER - IIRF	62,409	1,606	32,355	1,813,023	333,883	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	249,439	92,740	210,719	5,529,480	1,018,298	50.00
51.00	05100	RECOVERY ROOM	0	156	29,525	496,181	91,376	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	84,834	3,745	49,884	2,658,060	489,503	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	186,351	18,126	142,549	4,071,248	749,753	54.00
54.02	03630	ULTRA SOUND	0	2,225	89,797	960,466	176,877	54.02
56.00	05600	RADIOISOTOPE	29,663	16,848	28,665	818,040	150,649	56.00
57.00	05700	CT SCAN	0	28,079	336,808	1,774,768	326,838	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,781	22,905	468,503	86,279	59.00
60.00	06000	LABORATORY	0	57,952	420,678	5,722,299	1,053,807	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	39,360	8,831	137,522	2,166,003	398,887	65.00
66.00	06600	PHYSICAL THERAPY	20,331	656	22,785	1,096,706	201,967	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,134	336	23,186	784,059	144,391	67.00
68.00	06800	SPEECH PATHOLOGY	10,708	4,212	10,812	399,842	73,634	68.00
69.00	06900	ELECTROCARDIOLOGY	109,200	6,271	105,635	1,197,068	220,450	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	26	3,151	106,656	19,642	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	68,163	3,803,900	700,519	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	35,391	1,471,213	270,936	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	280,304	11,010	247,768	6,964,029	1,282,482	73.00
74.00	07400	RENAL DIALYSIS	11,153	8,491	21,966	941,985	173,474	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	382,173	13,457	863,646	11,335,782	2,087,575	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,855,015	461,352	3,521,572	118,800,420	18,476,198	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	27,025	4,977	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	28,089	5,173	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,855,015	461,352	3,521,572	118,855,534	18,486,348	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		6.00	7.00	8.00	9.00	10.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	NONPATIENT TELEPHONES					5.01	
5.02	00550	DATA PROCESSING					5.02	
5.03	00560	PURCHASING RECEIVING AND STORES					5.03	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04	
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05	
6.00	00600	MAINTENANCE & REPAIRS	0				6.00	
7.00	00700	OPERATION OF PLANT	0	8,607,917			7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	720,132	1,990,831		8.00	
9.00	00900	HOUSEKEEPING	0	0	0	2,487,338	9.00	
10.00	01000	DIETARY	0	445,234	0	140,400	10.00	
11.00	01100	CAFETERIA	0	337,304	0	106,366	11.00	
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00	
13.00	01300	NURSING ADMINISTRATION	0	52,079	0	16,423	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	270,723	0	85,370	14.00	
15.00	01500	PHARMACY	0	0	0	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	104,608	0	32,987	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,003,846	625,855	631,895	2,041,092	30.00
31.00	03100	INTENSIVE CARE UNIT	0	558,058	128,265	175,978	263,415	31.00
41.00	04100	SUBPROVIDER - I RF	0	301,701	128,061	95,139	206,805	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	703,296	92,793	221,778	0	50.00
51.00	05100	RECOVERY ROOM	0	49,341	16,239	15,559	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	442,675	90,755	139,593	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	612,606	99,120	193,180	0	54.00
54.02	03630	ULTRA SOUND	0	23,795	0	7,503	0	54.02
56.00	05600	RADIOISOTOPE	0	51,630	7,182	16,281	0	56.00
57.00	05700	CT SCAN	0	45,794	23,843	14,441	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	6,601	0	0	59.00
60.00	06000	LABORATORY	0	390,596	0	123,171	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	71,385	0	22,510	0	65.00
66.00	06600	PHYSICAL THERAPY	0	200,236	5,137	63,143	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	84,405	0	26,616	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	67,344	0	21,236	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69,589	7,278	21,944	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	84,494	0	26,644	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	101,016	0	31,854	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	7,444	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	644,258	752,258	203,161	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	8,436,145	1,990,831	2,433,172	2,511,312	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	80,723	0	25,455	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	91,049	0	28,711	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	8,607,917	1,990,831	2,487,338	2,511,312	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,754,808					11.00
12.00	01200	0	0				12.00
13.00	01300	77,024	0	1,969,675			13.00
14.00	01400	15,610	0	0	1,586,865		14.00
15.00	01500	0	0	0	0	-14,129	15.00
16.00	01600	61,689	0	0	0	0	16.00
17.00	01700	42,258	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	554,375	0	941,233	0	0	30.00
31.00	03100	106,819	0	169,666	0	0	31.00
41.00	04100	46,853	0	78,931	0	0	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	109,142	0	187,390	0	0	50.00
51.00	05100	9,516	0	16,276	0	0	51.00
52.00	05200	53,797	0	92,841	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	57,168	0	0	0	0	54.00
54.02	03630	19,356	0	0	0	0	54.02
56.00	05600	6,918	0	0	0	0	56.00
57.00	05700	20,130	0	0	0	0	57.00
59.00	05900	7,567	0	0	0	0	59.00
60.00	06000	61,264	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	52,298	0	0	0	0	65.00
66.00	06600	28,846	0	0	0	0	66.00
67.00	06700	20,704	0	0	0	0	67.00
68.00	06800	7,617	0	0	0	0	68.00
69.00	06900	25,325	0	0	0	0	69.00
70.00	07000	2,797	0	0	0	0	70.00
71.00	07100	0	0	0	1,146,290	0	71.00
72.00	07200	0	0	0	440,575	0	72.00
73.00	07300	62,763	0	0	0	0	73.00
74.00	07400	16,858	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	288,114	0	483,338	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,754,808	0	1,969,675	1,586,865	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	-14,129	201.00
202.00		1,754,808	0	1,969,675	1,586,865	-14,129	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
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Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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	3,988,798				16.00
17.00	01700	SOCIAL SERVICE	0	1,702,064			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	552,798	1,276,548	0	32,189,709	30.00
31.00	03100	INTENSIVE CARE UNIT	146,823	255,310	0	8,324,734	31.00
41.00	04100	SUBPROVIDER - I RF	36,649	0	0	3,041,045	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	238,680	0	0	8,100,857	50.00
51.00	05100	RECOVERY ROOM	33,443	0	0	727,931	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	56,504	34,041	0	4,057,769	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	161,465	0	0	5,944,540	54.00
54.02	03630	ULTRA SOUND	101,712	0	0	1,289,709	54.02
56.00	05600	RADIO SOTOPE	32,469	0	0	1,083,169	56.00
57.00	05700	CT SCAN	381,501	0	0	2,587,315	57.00
59.00	05900	CARDIAC CATHETERIZATION	25,944	0	0	594,894	59.00
60.00	06000	LABORATORY	476,499	0	0	7,827,636	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	155,770	0	0	2,866,853	65.00
66.00	06600	PHYSICAL THERAPY	25,809	0	0	1,621,844	66.00
67.00	06700	OCCUPATIONAL THERAPY	26,263	0	0	1,086,438	67.00
68.00	06800	SPEECH PATHOLOGY	12,247	0	0	581,920	68.00
69.00	06900	ELECTROCARDIOLOGY	119,652	0	0	1,661,306	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,569	0	0	243,802	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	77,208	0	0	5,727,917	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,087	0	0	2,222,811	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	280,646	0	0	8,722,790	73.00
74.00	07400	RENAL DIALYSIS	24,881	0	0	1,164,642	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	978,179	136,165	0	16,908,830	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,988,798	1,702,064	0	118,578,461	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	138,180	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	153,022	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	-14,129	201.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0133			Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/28/2017 11:20 am	
Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
202.00	TOTAL (sum lines 118-201)	3,988,798	1,702,064	0	118,855,534	25.00	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540 NONPATIENT TELEPHONES		5.01
5.02	00550 DATA PROCESSING		5.02
5.03	00560 PURCHASING RECEIVING AND STORES		5.03
5.04	00580 CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	00590 OTHER ADMINISTRATIVE & GENERAL		5.05
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	32,189,709	30.00
31.00	03100 INTENSIVE CARE UNIT	8,324,734	31.00
41.00	04100 SUBPROVIDER - IRF	3,041,045	41.00
43.00	04300 NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	8,100,857	50.00
51.00	05100 RECOVERY ROOM	727,931	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,057,769	52.00
53.00	05300 ANESTHESIOLOGY	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,944,540	54.00
54.02	03630 ULTRA SOUND	1,289,709	54.02
56.00	05600 RADIOISOTOPE	1,083,169	56.00
57.00	05700 CT SCAN	2,587,315	57.00
59.00	05900 CARDIAC CATHETERIZATION	594,894	59.00
60.00	06000 LABORATORY	7,827,636	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	62.30
65.00	06500 RESPIRATORY THERAPY	2,866,853	65.00
66.00	06600 PHYSICAL THERAPY	1,621,844	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,086,438	67.00
68.00	06800 SPEECH PATHOLOGY	581,920	68.00
69.00	06900 ELECTROCARDIOLOGY	1,661,306	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	243,802	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,727,917	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,222,811	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,722,790	73.00
74.00	07400 RENAL DIALYSIS	1,164,642	74.00
76.97	07697 CARDIAC REHABILITATION	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699 LI THOTRI PSY	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0	90.00
91.00	09100 EMERGENCY	16,908,830	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0	94.00
99.20	09921 OPT	0	99.20
99.30	09931 OOT	0	99.30
99.40	09941 OSP	0	99.40
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	118,578,461	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	138,180	190.00
190.01	19001 SISTERS & PRIESTS MAINTENANCE	0	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950 SEASON HOSPICE	153,022	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	-14,129	201.00
202.00	TOTAL (sum lines 118-201)	118,855,534	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
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	30,194	646	30,840	30,840 4.00
5.01 00540	NONPATIENT TELEPHONES	0	3,726	105,003	108,729	191 5.01
5.02 00550	DATA PROCESSING	0	21,205	1,545,015	1,566,220	770 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	14,682	0	14,682	140 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	30,887	192	31,079	366 5.04
5.05 00590	OTHER ADMINISTRATIVE & GENERAL	0	521,962	18,462	540,424	2,053 5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	204,851	51,598	256,449	1,301 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	222,165	0	222,165	0 8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	584 9.00
10.00 01000	DIETARY	0	137,357	23,582	160,939	308 10.00
11.00 01100	CAFETERIA	0	104,060	0	104,060	215 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	16,067	255,267	271,334	532 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	83,519	347,427	430,946	103 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	32,272	4,215	36,487	742 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	627 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	618,196	158,795	776,991	7,550 30.00
31.00 03100	INTENSIVE CARE UNIT	0	172,164	102,966	275,130	1,869 31.00
41.00 04100	SUBPROVIDER - IIRF	0	93,076	19,702	112,778	686 41.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	216,971	349,677	566,648	1,604 50.00
51.00 05100	RECOVERY ROOM	0	15,222	13,577	28,799	194 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	136,567	201,621	338,188	928 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	188,992	1,067,507	1,256,499	942 54.00
54.02 03630	ULTRA SOUND	0	7,341	1,043	8,384	372 54.02
56.00 05600	RADIOISOTOPE	0	15,928	109,911	125,839	155 56.00
57.00 05700	CT SCAN	0	14,128	225,896	240,024	323 57.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	33,167	33,167	130 59.00
60.00 06000	LABORATORY	0	120,501	68,775	189,276	805 60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	0	22,023	96,245	118,268	766 65.00
66.00 06600	PHYSICAL THERAPY	0	61,774	2,556	64,330	435 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	26,039	0	26,039	321 67.00
68.00 06800	SPEECH PATHOLOGY	0	20,776	0	20,776	128 68.00
69.00 06900	ELECTROCARDIOLOGY	0	21,469	192,069	213,538	299 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	26,067	5,084	31,151	32 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	31,164	78,537	109,701	1,174 73.00
74.00 07400	RENAL DIALYSIS	0	0	34,031	34,031	316 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	0	198,757	108,934	307,691	3,879 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
99.20 09921	OPT	0	0	0	0	0 99.20
99.30 09931	OOT	0	0	0	0	0 99.30
99.40 09941	OSP	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	3,430,102	5,221,500	8,651,602	30,840 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,903	0	24,903	0 190.00
190.01 19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0 190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	SEASON HOSPICE	0	28,089	0	28,089	0 194.00
200.00	Cross Foot Adjustments				0	200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	2A	4.00	
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	3,483,094	5,221,500	8,704,594	30,840	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE & GENERAL	
			5.01	5.02	5.03	5.04	5.05	
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
5.01	00540	NONPATIENT TELEPHONES	108,920					5.01
5.02	00550	DATA PROCESSING	2,650	1,569,640				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,590	19,789	36,201			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,537	332,151	71	370,204		5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	30,034	427,300	749	0	1,000,560	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,329	18,057	3,157	0	72,452	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,492	3,970	0	10,695	8.00
9.00	00900	HOUSEKEEPING	0	0	46	0	20,936	9.00
10.00	01000	DIETARY	2,032	0	1,357	0	16,208	10.00
11.00	01100	CAFETERIA	0	0	0	0	11,036	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	177	1,249	326	0	15,354	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	972	10,868	1,320	0	10,228	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,244	106,265	284	0	31,896	16.00
17.00	01700	SOCIAL SERVICE	0	0	14	0	13,971	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,229	211,606	1,302	51,289	198,362	30.00
31.00	03100	INTENSIVE CARE UNIT	1,855	44,494	492	13,622	54,882	31.00
41.00	04100	SUBPROVIDER - IIRF	2,738	16,731	126	3,400	18,070	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,862	66,871	7,280	22,145	55,112	50.00
51.00	05100	RECOVERY ROOM	0	0	12	3,103	4,945	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,743	294	5,242	26,493	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,127	49,958	1,422	14,981	40,578	54.00
54.02	03630	ULTRA SOUND	0	0	175	9,437	9,573	54.02
56.00	05600	RADIOISOTOPE	0	7,952	1,322	3,012	8,153	56.00
57.00	05700	CT SCAN	0	0	2,203	35,396	17,689	57.00
59.00	05900	CARDIAC CATHETERIZATION	618	0	1,552	2,407	4,670	59.00
60.00	06000	LABORATORY	3,710	0	4,547	44,210	57,034	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,552	693	14,452	21,589	65.00
66.00	06600	PHYSICAL THERAPY	972	5,450	51	2,395	10,931	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,376	26	2,437	7,815	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,871	330	1,136	3,985	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,275	492	11,101	11,931	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2	331	1,063	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,163	37,913	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,719	14,664	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,943	75,145	864	26,038	69,410	73.00
74.00	07400	RENAL DIALYSIS	0	2,990	666	2,308	9,389	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,124	102,455	1,056	90,880	112,984	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	108,743	1,569,640	36,201	370,204	1,000,011	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	177	0	0	0	269	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	0	280	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	108,920	1,569,640	36,201	370,204	1,000,560	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/28/2017 11:20 am		
Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			6.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	355,745			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	29,761	270,083		8.00
9.00	00900	HOUSEKEEPING	0	0	0	21,566	9.00
10.00	01000	DIETARY	0	18,400	0	1,217	200,461
11.00	01100	CAFETERIA	0	13,940	0	922	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	2,152	0	142	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,188	0	740	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,323	0	286	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	82,815	84,906	5,481	162,926
31.00	03100	INTENSIVE CARE UNIT	0	23,063	17,401	1,526	21,027
41.00	04100	SUBPROVIDER - I RF	0	12,469	17,373	825	16,508
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	29,066	12,589	1,923	0
51.00	05100	RECOVERY ROOM	0	2,039	2,203	135	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,295	12,312	1,210	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,318	13,447	1,675	0
54.02	03630	ULTRA SOUND	0	983	0	65	0
56.00	05600	RADIOISOTOPE	0	2,134	974	141	0
57.00	05700	CT SCAN	0	1,893	3,235	125	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	895	0	0
60.00	06000	LABORATORY	0	16,142	0	1,068	0
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	2,950	0	195	0
66.00	06600	PHYSICAL THERAPY	0	8,275	697	547	0
67.00	06700	OCCUPATIONAL THERAPY	0	3,488	0	231	0
68.00	06800	SPEECH PATHOLOGY	0	2,783	0	184	0
69.00	06900	ELECTROCARDIOLOGY	0	2,876	987	190	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,492	0	231	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,175	0	276	0
74.00	07400	RENAL DIALYSIS	0	0	1,010	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	26,626	102,054	1,761	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.20	09921	OPT	0	0	0	0	0
99.30	09931	OOT	0	0	0	0	0
99.40	09941	OSP	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	348,646	270,083	21,096	200,461
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,336	0	221	0
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	SEASON HOSPICE	0	3,763	0	249	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	355,745	270,083	21,566	200,461

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	130,173					11.00
12.00	01200	0	0				12.00
13.00	01300	5,714	0	296,980			13.00
14.00	01400	1,158	0	0	467,523		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	4,576	0	0	0	0	16.00
17.00	01700	3,135	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	41,120	0	141,915	0	0	30.00
31.00	03100	7,924	0	25,582	0	0	31.00
41.00	04100	3,476	0	11,901	0	0	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,096	0	28,254	0	0	50.00
51.00	05100	706	0	2,454	0	0	51.00
52.00	05200	3,991	0	13,998	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	4,241	0	0	0	0	54.00
54.02	03630	1,436	0	0	0	0	54.02
56.00	05600	513	0	0	0	0	56.00
57.00	05700	1,493	0	0	0	0	57.00
59.00	05900	561	0	0	0	0	59.00
60.00	06000	4,545	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	3,880	0	0	0	0	65.00
66.00	06600	2,140	0	0	0	0	66.00
67.00	06700	1,536	0	0	0	0	67.00
68.00	06800	565	0	0	0	0	68.00
69.00	06900	1,879	0	0	0	0	69.00
70.00	07000	208	0	0	0	0	70.00
71.00	07100	0	0	0	337,720	0	71.00
72.00	07200	0	0	0	129,803	0	72.00
73.00	07300	4,656	0	0	0	0	73.00
74.00	07400	1,251	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	21,373	0	72,876	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		130,173	0	296,980	467,523	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		130,173	0	296,980	467,523	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
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	192,103				16.00
17.00	01700	SOCIAL SERVICE	0	17,747			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,607	13,310		1,826,409	30.00
31.00	03100	INTENSIVE CARE UNIT	7,067	2,662		498,596	31.00
41.00	04100	SUBPROVIDER - I RF	1,764	0		218,845	41.00
43.00	04300	NURSERY	0	0		0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,488	0		818,938	50.00
51.00	05100	RECOVERY ROOM	1,610	0		46,200	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,720	355		446,769	52.00
53.00	05300	ANESTHESIOLOGY	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,771	0		1,424,959	54.00
54.02	03630	ULTRA SOUND	4,895	0		35,320	54.02
56.00	05600	RADIOISOTOPE	1,563	0		151,758	56.00
57.00	05700	CT SCAN	18,362	0		320,743	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,249	0		45,249	59.00
60.00	06000	LABORATORY	22,934	0		344,271	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		0	62.30
65.00	06500	RESPIRATORY THERAPY	7,497	0		180,842	65.00
66.00	06600	PHYSICAL THERAPY	1,242	0		97,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,264	0		44,533	67.00
68.00	06800	SPEECH PATHOLOGY	589	0		33,347	68.00
69.00	06900	ELECTROCARDIOLOGY	5,759	0		278,327	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	172	0		36,682	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,716	0		386,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,929	0		150,115	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,508	0		306,890	73.00
74.00	07400	RENAL DIALYSIS	1,198	0		53,159	74.00
76.97	07697	CARDIAC REHABILITATION	0	0		0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		0	76.98
76.99	07699	LITHOTRIPSY	0	0		0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0		0	90.00
91.00	09100	EMERGENCY	47,199	1,420		897,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0		0	94.00
99.20	09921	OPT	0	0		0	99.20
99.30	09931	OOT	0	0		0	99.30
99.40	09941	OSP	0	0		0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	192,103	17,747	0	8,643,307	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		28,906	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0		0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	192.00
194.00	07950	SEASON HOSPICE	0	0		32,381	194.00
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0133			Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/28/2017 11:20 am	
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
202.00 TOTAL (sum lines 118-201)	16.00 192,103	17.00 17,747	19.00 0	24.00 8,704,594	25.00 0			202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100		1.00
2.00	00200		2.00
4.00	00400		4.00
5.01	00540		5.01
5.02	00550		5.02
5.03	00560		5.03
5.04	00580		5.04
5.05	00590		5.05
6.00	00600		6.00
7.00	00700		7.00
8.00	00800		8.00
9.00	00900		9.00
10.00	01000		10.00
11.00	01100		11.00
12.00	01200		12.00
13.00	01300		13.00
14.00	01400		14.00
15.00	01500		15.00
16.00	01600		16.00
17.00	01700		17.00
19.00	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	1,826,409	30.00
31.00	03100	498,596	31.00
41.00	04100	218,845	41.00
43.00	04300	0	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	818,938	50.00
51.00	05100	46,200	51.00
52.00	05200	446,769	52.00
53.00	05300	0	53.00
54.00	05400	1,424,959	54.00
54.02	03630	35,320	54.02
56.00	05600	151,758	56.00
57.00	05700	320,743	57.00
59.00	05900	45,249	59.00
60.00	06000	344,271	60.00
62.30	06250	0	62.30
65.00	06500	180,842	65.00
66.00	06600	97,465	66.00
67.00	06700	44,533	67.00
68.00	06800	33,347	68.00
69.00	06900	278,327	69.00
70.00	07000	36,682	70.00
71.00	07100	386,512	71.00
72.00	07200	150,115	72.00
73.00	07300	306,890	73.00
74.00	07400	53,159	74.00
76.97	07697	0	76.97
76.98	07698	0	76.98
76.99	07699	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	0	90.00
91.00	09100	897,378	91.00
92.00	09200		92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	0	94.00
99.20	09921	0	99.20
99.30	09931	0	99.30
99.40	09941	0	99.40
SPECIAL PURPOSE COST CENTERS			
113.00	11300		113.00
118.00		8,643,307	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	28,906	190.00
190.01	19001	0	190.01
192.00	19200	0	192.00
194.00	07950	32,381	194.00
200.00		0	200.00
201.00		0	201.00
202.00		8,704,594	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	251,475				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,039,806			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,180	376	57,435,650		4.00
5.01 00540	NONPATIENT TELEPHONES	269	61,130	356,190	1,233	5.01
5.02 00550	DATA PROCESSING	1,531	899,461	1,433,928	30	1,182,745 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	1,060	0	260,966	18	14,911 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,230	112	681,397	74	250,280 5.04
5.05 00590	OTHER ADMINISTRATIVE & GENERAL	37,685	10,748	3,822,273	340	321,978 5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	14,790	30,039	2,423,531	49	13,606 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	16,040	0	0	0	2,631 8.00
9.00 00900	HOUSEKEEPING	0	0	1,087,984	0	0 9.00
10.00 01000	DIETARY	9,917	13,729	572,864	23	0 10.00
11.00 01100	CAFETERIA	7,513	0	400,702	0	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	1,160	148,609	989,763	2	941 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,030	202,262	191,557	11	8,189 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,330	2,454	1,381,730	82	80,072 16.00
17.00 01700	SOCIAL SERVICE	0	0	1,167,723	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	44,633	92,446	14,065,300	229	159,448 30.00
31.00 03100	INTENSIVE CARE UNIT	12,430	59,944	3,479,978	21	33,527 31.00
41.00 04100	SUBPROVIDER - I RF	6,720	11,470	1,276,866	31	12,607 41.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	15,665	203,572	2,987,769	89	50,388 50.00
51.00 05100	RECOVERY ROOM	1,099	7,904	361,924	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,860	117,378	1,727,905	0	17,137 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,645	621,472	1,753,800	92	37,644 54.00
54.02 03630	ULTRA SOUND	530	607	693,148	0	0 54.02
56.00 05600	RADIOISOTOPE	1,150	63,987	288,253	0	5,992 56.00
57.00 05700	CT SCAN	1,020	131,510	600,960	0	0 57.00
59.00 05900	CARDIAC CATHETERIZATION	0	19,309	242,216	7	0 59.00
60.00 06000	LABORATORY	8,700	40,039	1,499,024	42	0 60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	1,590	56,031	1,426,956	0	7,951 65.00
66.00 06600	PHYSICAL THERAPY	4,460	1,488	810,330	11	4,107 66.00
67.00 06700	OCCUPATIONAL THERAPY	1,880	0	598,564	0	1,037 67.00
68.00 06800	SPEECH PATHOLOGY	1,500	0	237,698	0	2,163 68.00
69.00 06900	ELECTROCARDIOLOGY	1,550	111,817	556,174	0	22,059 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,882	2,960	60,350	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,250	45,722	2,186,675	22	56,623 73.00
74.00 07400	RENAL DIALYSIS	0	19,812	587,921	0	2,253 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	14,350	63,418	7,223,231	58	77,201 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
99.20 09921	OPT	0	0	0	0	0 99.20
99.30 09931	OOT	0	0	0	0	0 99.30
99.40 09941	OSP	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	247,649	3,039,806	57,435,650	1,231	1,182,745 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,798	0	0	2	0 190.00
190.01 19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0 190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	SEASON HOSPICE	2,028	0	0	0	0 194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
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)	3,483,094	5,221,500	10,654,112	1,307,977	5,855,015	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	13.850657	1.717708	0.185496	1,060.808597	4.950361	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			30,840	108,920	1,569,640	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000537	88.337388	1.327116	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		PURCHASING RECEIVING AND STORES (COSTED REQUISITION)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560	7,179,800					5.03
5.04	00580	14,159	603,729,136				5.04
5.05	00590	148,461	0	-18,486,348	100,383,315		5.05
6.00	00600	0	0	0	0	0	6.00
7.00	00700	626,190	0	0	7,269,230	0	7.00
8.00	00800	787,303	0	0	1,073,082	0	8.00
9.00	00900	9,092	0	0	2,100,512	0	9.00
10.00	01000	269,092	0	0	1,626,200	0	10.00
11.00	01100	0	0	0	1,107,232	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	64,735	0	0	1,540,461	0	13.00
14.00	01400	261,896	0	0	1,026,182	0	14.00
15.00	01500	0	0	14,129	0	0	15.00
16.00	01600	56,326	0	0	3,200,176	0	16.00
17.00	01700	2,848	0	0	1,401,676	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	258,191	83,668,570	0	19,897,779	0	30.00
31.00	03100	97,584	22,222,314	0	5,506,360	0	31.00
41.00	04100	24,995	5,546,968	0	1,813,023	0	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,443,283	36,125,255	0	5,529,480	0	50.00
51.00	05100	2,435	5,061,765	0	496,181	0	51.00
52.00	05200	58,288	8,552,068	0	2,658,060	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	282,080	24,438,403	0	4,071,248	0	54.00
54.02	03630	34,619	15,394,638	0	960,466	0	54.02
56.00	05600	262,196	4,914,352	0	818,040	0	56.00
57.00	05700	436,982	57,741,884	0	1,774,768	0	57.00
59.00	05900	307,845	3,926,814	0	468,503	0	59.00
60.00	06000	901,874	72,120,360	0	5,722,299	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	137,436	23,576,481	0	2,166,003	0	65.00
66.00	06600	10,212	3,906,254	0	1,096,706	0	66.00
67.00	06700	5,229	3,974,957	0	784,059	0	67.00
68.00	06800	65,546	1,853,619	0	399,842	0	68.00
69.00	06900	97,598	18,109,860	0	1,197,068	0	69.00
70.00	07000	403	540,203	0	106,656	0	70.00
71.00	07100	0	11,685,815	0	3,803,900	0	71.00
72.00	07200	0	6,067,362	0	1,471,213	0	72.00
73.00	07300	171,337	42,477,002	0	6,964,029	0	73.00
74.00	07400	132,147	3,765,873	0	941,985	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	209,418	148,058,319	0	11,335,782	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		7,179,800	603,729,136	-18,472,219	100,328,201	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	27,025	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	28,089	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		PURCHASING RECEIVING AND STORES (COSTED REQUISITION)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	461,352	3,521,572		18,486,348		0 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.064257	0.005833		0.184158	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	36,201	370,204		1,000,560		0 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.005042	0.000613		0.009967	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	191,730					8.00
9.00	00900	16,040	1,213,361				9.00
10.00	01000	0	0	175,690			10.00
11.00	01100	9,917	0	9,917	155,132		11.00
12.00	01200	7,513	0	7,513	0	70,262	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	1,160	0	1,160	0	3,084	14.00
15.00	01500	6,030	0	6,030	0	625	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	2,330	0	2,330	0	2,470	17.00
18.00	01800	0	0	0	0	1,692	18.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,633	381,443	44,633	126,085	22,197	30.00
31.00	03100	12,430	78,174	12,430	16,272	4,277	31.00
41.00	04100	6,720	78,050	6,720	12,775	1,876	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	15,665	56,555	15,665	0	4,370	50.00
51.00	05100	1,099	9,897	1,099	0	381	51.00
52.00	05200	9,860	55,313	9,860	0	2,154	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	13,645	60,411	13,645	0	2,289	54.00
54.02	03630	530	0	530	0	775	54.02
56.00	05600	1,150	4,377	1,150	0	277	56.00
57.00	05700	1,020	14,532	1,020	0	806	57.00
59.00	05900	0	4,023	0	0	303	59.00
60.00	06000	8,700	0	8,700	0	2,453	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,590	0	1,590	0	2,094	65.00
66.00	06600	4,460	3,131	4,460	0	1,155	66.00
67.00	06700	1,880	0	1,880	0	829	67.00
68.00	06800	1,500	0	1,500	0	305	68.00
69.00	06900	1,550	4,436	1,550	0	1,014	69.00
70.00	07000	1,882	0	1,882	0	112	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,250	0	2,250	0	2,513	73.00
74.00	07400	0	4,537	0	0	675	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	14,350	458,482	14,350	0	11,536	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		187,904	1,213,361	171,864	155,132	70,262	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,798	0	1,798	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	2,028	0	2,028	0	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	8,607,917	1,990,831	2,487,338	2,511,312	1,754,808	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	44.896036	1.640757	14.157539	16.188227	24.975207	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	355,745	270,083	21,566	200,461	130,173	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.855448	0.222591	0.122750	1.292196	1.852680	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200	0					12.00
13.00	01300	0	957,604				13.00
14.00	01400	0	0	5,171,559			14.00
15.00	01500	0	0	0	0		15.00
16.00	01600	0	0	0	0	603,729,136	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	457,603	0	0	83,668,570	30.00
31.00	03100	0	82,487	0	0	22,222,314	31.00
41.00	04100	0	38,374	0	0	5,546,968	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	91,104	0	0	36,125,255	50.00
51.00	05100	0	7,913	0	0	5,061,765	51.00
52.00	05200	0	45,137	0	0	8,552,068	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	24,438,403	54.00
54.02	03630	0	0	0	0	15,394,638	54.02
56.00	05600	0	0	0	0	4,914,352	56.00
57.00	05700	0	0	0	0	57,741,884	57.00
59.00	05900	0	0	0	0	3,926,814	59.00
60.00	06000	0	0	0	0	72,120,360	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	23,576,481	65.00
66.00	06600	0	0	0	0	3,906,254	66.00
67.00	06700	0	0	0	0	3,974,957	67.00
68.00	06800	0	0	0	0	1,853,619	68.00
69.00	06900	0	0	0	0	18,109,860	69.00
70.00	07000	0	0	0	0	540,203	70.00
71.00	07100	0	0	3,735,737	0	11,685,815	71.00
72.00	07200	0	0	1,435,822	0	6,067,362	72.00
73.00	07300	0	0	0	0	42,477,002	73.00
74.00	07400	0	0	0	0	3,765,873	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	234,986	0	0	148,058,319	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		0	957,604	5,171,559	0	603,729,136	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		12.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	1,969,675	1,586,865	-14,129	3,988,798	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	2.056878	0.306845	0.000000	0.006607	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	296,980	467,523	0	192,103	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.310128	0.090403	0.000000	0.000318	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
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
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL		5.05
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
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	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	75	30.00
31.00	03100	INTENSIVE CARE UNIT	15	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.02	03630	ULTRA SOUND	0	54.02
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIpsy	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	8	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	94.00
99.20	09921	OPT	0	99.20
99.30	09931	OOT	0	99.30
99.40	09941	OSP	0	99.40
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	SEASON HOSPICE	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet B-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	1,702,064	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	17,020.640000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	17,747	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	177.470000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
1.00	2.00	3.00	4.00	5.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	32,189,709		32,189,709	0	32,189,709	30.00
31.00	03100 INTENSIVE CARE UNIT	8,324,734		8,324,734	0	8,324,734	31.00
41.00	04100 SUBPROVIDER - I RF	3,041,045		3,041,045	8,709	3,049,754	41.00
43.00	04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	8,100,857		8,100,857	0	8,100,857	50.00
51.00	05100 RECOVERY ROOM	727,931		727,931	0	727,931	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,057,769		4,057,769	0	4,057,769	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,944,540		5,944,540	0	5,944,540	54.00
54.02	03630 ULTRASOUND	1,289,709		1,289,709	0	1,289,709	54.02
56.00	05600 RADIOISOTOPE	1,083,169		1,083,169	0	1,083,169	56.00
57.00	05700 CT SCAN	2,587,315		2,587,315	0	2,587,315	57.00
59.00	05900 CARDIAC CATHETERIZATION	594,894		594,894	0	594,894	59.00
60.00	06000 LABORATORY	7,827,636		7,827,636	0	7,827,636	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	2,866,853	0	2,866,853	0	2,866,853	65.00
66.00	06600 PHYSICAL THERAPY	1,621,844	0	1,621,844	0	1,621,844	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,086,438	0	1,086,438	0	1,086,438	67.00
68.00	06800 SPEECH PATHOLOGY	581,920	0	581,920	0	581,920	68.00
69.00	06900 ELECTROCARDIOLOGY	1,661,306		1,661,306	0	1,661,306	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	243,802		243,802	0	243,802	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,727,917		5,727,917	0	5,727,917	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,222,811		2,222,811	0	2,222,811	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,722,790		8,722,790	0	8,722,790	73.00
74.00	07400 RENAL DIALYSIS	1,164,642		1,164,642	0	1,164,642	74.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	16,908,830		16,908,830	0	16,908,830	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,879,425		4,879,425		4,879,425	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.20	09921 OPT	0		0		0	99.20
99.30	09931 OOT	0		0		0	99.30
99.40	09941 OSP	0		0		0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	123,457,886	0	123,457,886	8,709	123,466,595	200.00
201.00	Less Observation Beds	4,879,425		4,879,425		4,879,425	201.00
202.00	Total (see instructions)	118,578,461	0	118,578,461	8,709	118,587,170	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part I
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS
		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	74,235,689		74,235,689		30.00
31.00	03100	INTENSIVE CARE UNIT	22,222,314		22,222,314		31.00
41.00	04100	SUBPROVIDER - IRF	5,546,968		5,546,968		41.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,052,240	16,073,015	36,125,255	0.224244	50.00
51.00	05100	RECOVERY ROOM	2,728,028	2,333,737	5,061,765	0.143810	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,266,572	1,285,496	8,552,068	0.474478	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,002,074	14,436,329	24,438,403	0.243246	54.00
54.02	03630	ULTRA SOUND	6,998,442	8,396,196	15,394,638	0.083777	54.02
56.00	05600	RADIOISOTOPE	2,807,629	2,106,723	4,914,352	0.220409	56.00
57.00	05700	CT SCAN	24,560,352	33,181,532	57,741,884	0.044808	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,197,314	729,500	3,926,814	0.151495	59.00
60.00	06000	LABORATORY	38,982,814	33,137,546	72,120,360	0.108536	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	21,750,782	1,825,699	23,576,481	0.121598	65.00
66.00	06600	PHYSICAL THERAPY	3,158,976	747,278	3,906,254	0.415192	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,168,725	806,232	3,974,957	0.273321	67.00
68.00	06800	SPEECH PATHOLOGY	1,350,152	503,467	1,853,619	0.313937	68.00
69.00	06900	ELECTROCARDIOLOGY	10,604,708	7,505,152	18,109,860	0.091735	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	357,505	182,698	540,203	0.451316	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,438,016	2,247,799	11,685,815	0.490160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,564,483	1,502,879	6,067,362	0.366355	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,766,141	9,710,861	42,477,002	0.205353	73.00
74.00	07400	RENAL DIALYSIS	3,476,837	289,036	3,765,873	0.309262	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	47,064,422	100,993,897	148,058,319	0.114204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	9,432,881	0.517278	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.20	09921	OPT	0	0	0		99.20
99.30	09931	OOT	0	0	0		99.30
99.40	09941	OSP	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	356,301,183	247,427,953	603,729,136		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	356,301,183	247,427,953	603,729,136		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 11:20 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.224244		50.00
51.00	05100 RECOVERY ROOM	0.143810		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.474478		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.243246		54.00
54.02	03630 ULTRA SOUND	0.083777		54.02
56.00	05600 RADIOISOTOPE	0.220409		56.00
57.00	05700 CT SCAN	0.044808		57.00
59.00	05900 CARDIAC CATHETERIZATION	0.151495		59.00
60.00	06000 LABORATORY	0.108536		60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.121598		65.00
66.00	06600 PHYSICAL THERAPY	0.415192		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273321		67.00
68.00	06800 SPEECH PATHOLOGY	0.313937		68.00
69.00	06900 ELECTROCARDIOLOGY	0.091735		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.451316		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.490160		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.366355		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205353		73.00
74.00	07400 RENAL DIALYSIS	0.309262		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.114204		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.517278		92.00
	OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
99.20	09921 OPT			99.20
99.30	09931 OOT			99.30
99.40	09941 OSP			99.40
	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: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part I
Date/Time Prepared:
11/28/2017 11:20 am

		Title XIX		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	32,189,709	32,189,709	0	32,189,709	30.00
31.00	03100 INTENSIVE CARE UNIT	8,324,734	8,324,734	0	8,324,734	31.00
41.00	04100 SUBPROVIDER - I RF	3,041,045	3,041,045	8,709	3,049,754	41.00
43.00	04300 NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8,100,857	8,100,857	0	8,100,857	50.00
51.00	05100 RECOVERY ROOM	727,931	727,931	0	727,931	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,057,769	4,057,769	0	4,057,769	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,944,540	5,944,540	0	5,944,540	54.00
54.02	03630 ULTRASOUND	1,289,709	1,289,709	0	1,289,709	54.02
56.00	05600 RADIOISOTOPE	1,083,169	1,083,169	0	1,083,169	56.00
57.00	05700 CT SCAN	2,587,315	2,587,315	0	2,587,315	57.00
59.00	05900 CARDIAC CATHETERIZATION	594,894	594,894	0	594,894	59.00
60.00	06000 LABORATORY	7,827,636	7,827,636	0	7,827,636	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	2,866,853	2,866,853	0	2,866,853	65.00
66.00	06600 PHYSICAL THERAPY	1,621,844	1,621,844	0	1,621,844	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,086,438	1,086,438	0	1,086,438	67.00
68.00	06800 SPEECH PATHOLOGY	581,920	581,920	0	581,920	68.00
69.00	06900 ELECTROCARDIOLOGY	1,661,306	1,661,306	0	1,661,306	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	243,802	243,802	0	243,802	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,727,917	5,727,917	0	5,727,917	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,222,811	2,222,811	0	2,222,811	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,722,790	8,722,790	0	8,722,790	73.00
74.00	07400 RENAL DIALYSIS	1,164,642	1,164,642	0	1,164,642	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	90.00
91.00	09100 EMERGENCY	16,908,830	16,908,830	0	16,908,830	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,879,425	4,879,425	0	4,879,425	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.20	09921 OPT	0	0	0	0	99.20
99.30	09931 OOT	0	0	0	0	99.30
99.40	09941 OSP	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	123,457,886	123,457,886	8,709	123,466,595	200.00
201.00	Less Observation Beds	4,879,425	4,879,425		4,879,425	201.00
202.00	Total (see instructions)	118,578,461	118,578,461	8,709	118,587,170	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part I
Date/Time Prepared:
11/28/2017 11:20 am

		Title XIX			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	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	74,235,689		74,235,689		30.00
31.00	03100	INTENSIVE CARE UNIT	22,222,314		22,222,314		31.00
41.00	04100	SUBPROVIDER - IRF	5,546,968		5,546,968		41.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,052,240	16,073,015	36,125,255	0.224244	50.00
51.00	05100	RECOVERY ROOM	2,728,028	2,333,737	5,061,765	0.143810	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,266,572	1,285,496	8,552,068	0.474478	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,002,074	14,436,329	24,438,403	0.243246	54.00
54.02	03630	ULTRA SOUND	6,998,442	8,396,196	15,394,638	0.083777	54.02
56.00	05600	RADIOISOTOPE	2,807,629	2,106,723	4,914,352	0.220409	56.00
57.00	05700	CT SCAN	24,560,352	33,181,532	57,741,884	0.044808	57.00
59.00	05900	CARDIAC CATHETERIZATION	3,197,314	729,500	3,926,814	0.151495	59.00
60.00	06000	LABORATORY	38,982,814	33,137,546	72,120,360	0.108536	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	21,750,782	1,825,699	23,576,481	0.121598	65.00
66.00	06600	PHYSICAL THERAPY	3,158,976	747,278	3,906,254	0.415192	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,168,725	806,232	3,974,957	0.273321	67.00
68.00	06800	SPEECH PATHOLOGY	1,350,152	503,467	1,853,619	0.313937	68.00
69.00	06900	ELECTROCARDIOLOGY	10,604,708	7,505,152	18,109,860	0.091735	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	357,505	182,698	540,203	0.451316	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,438,016	2,247,799	11,685,815	0.490160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,564,483	1,502,879	6,067,362	0.366355	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,766,141	9,710,861	42,477,002	0.205353	73.00
74.00	07400	RENAL DIALYSIS	3,476,837	289,036	3,765,873	0.309262	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	47,064,422	100,993,897	148,058,319	0.114204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	9,432,881	0.517278	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.20	09921	OPT	0	0	0		99.20
99.30	09931	OOT	0	0	0		99.30
99.40	09941	OSP	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	356,301,183	247,427,953	603,729,136		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	356,301,183	247,427,953	603,729,136		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/28/2017 11:20 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.224244		50.00
51.00	05100 RECOVERY ROOM	0.143810		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.474478		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.243246		54.00
54.02	03630 ULTRA SOUND	0.083777		54.02
56.00	05600 RADIOISOTOPE	0.220409		56.00
57.00	05700 CT SCAN	0.044808		57.00
59.00	05900 CARDIAC CATHETERIZATION	0.151495		59.00
60.00	06000 LABORATORY	0.108536		60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.121598		65.00
66.00	06600 PHYSICAL THERAPY	0.415192		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273321		67.00
68.00	06800 SPEECH PATHOLOGY	0.313937		68.00
69.00	06900 ELECTROCARDIOLOGY	0.091735		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.451316		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.490160		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.366355		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205353		73.00
74.00	07400 RENAL DIALYSIS	0.309262		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.114204		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.517278		92.00
	OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
99.20	09921 OPT			99.20
99.30	09931 OOT			99.30
99.40	09941 OSP			99.40
	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

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0133

Period: From 07/01/2016 To 06/30/2017

Worksheet C Part II Date/Time Prepared: 11/28/2017 11:20 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,100,857	818,938	7,281,919	0	0	50.00
51.00	05100	RECOVERY ROOM	727,931	46,200	681,731	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,057,769	446,769	3,611,000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,944,540	1,424,959	4,519,581	0	0	54.00
54.02	03630	ULTRA SOUND	1,289,709	35,320	1,254,389	0	0	54.02
56.00	05600	RADIOISOTOPE	1,083,169	151,758	931,411	0	0	56.00
57.00	05700	CT SCAN	2,587,315	320,743	2,266,572	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	594,894	45,249	549,645	0	0	59.00
60.00	06000	LABORATORY	7,827,636	344,271	7,483,365	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,866,853	180,842	2,686,011	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,621,844	97,465	1,524,379	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,086,438	44,533	1,041,905	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	581,920	33,347	548,573	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,661,306	278,327	1,382,979	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	243,802	36,682	207,120	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,727,917	386,512	5,341,405	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,222,811	150,115	2,072,696	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,722,790	306,890	8,415,900	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,164,642	53,159	1,111,483	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	16,908,830	897,378	16,011,452	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,879,425	276,854	4,602,571	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	79,902,398	6,376,311	73,526,087	0	0	200.00
201.00		Less Observation Beds	4,879,425	276,854	4,602,571	0	0	201.00
202.00		Total (line 200 minus line 201)	75,022,973	6,099,457	68,923,516	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet C
Part II
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8,100,857	36,125,255	0.224244		50.00
51.00	05100 RECOVERY ROOM	727,931	5,061,765	0.143810		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,057,769	8,552,068	0.474478		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,944,540	24,438,403	0.243246		54.00
54.02	03630 ULTRA SOUND	1,289,709	15,394,638	0.083777		54.02
56.00	05600 RADIOISOTOPE	1,083,169	4,914,352	0.220409		56.00
57.00	05700 CT SCAN	2,587,315	57,741,884	0.044808		57.00
59.00	05900 CARDIAC CATHETERIZATION	594,894	3,926,814	0.151495		59.00
60.00	06000 LABORATORY	7,827,636	72,120,360	0.108536		60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	2,866,853	23,576,481	0.121598		65.00
66.00	06600 PHYSICAL THERAPY	1,621,844	3,906,254	0.415192		66.00
67.00	06700 OCCUPATIONAL THERAPY	1,086,438	3,974,957	0.273321		67.00
68.00	06800 SPEECH PATHOLOGY	581,920	1,853,619	0.313937		68.00
69.00	06900 ELECTROCARDIOLOGY	1,661,306	18,109,860	0.091735		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	243,802	540,203	0.451316		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,727,917	11,685,815	0.490160		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,222,811	6,067,362	0.366355		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,722,790	42,477,002	0.205353		73.00
74.00	07400 RENAL DIALYSIS	1,164,642	3,765,873	0.309262		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000		90.00
91.00	09100 EMERGENCY	16,908,830	148,058,319	0.114204		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,879,425	9,432,881	0.517278		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.20	09921 OPT	0	0	0.000000		99.20
99.30	09931 OOT	0	0	0.000000		99.30
99.40	09941 OSP	0	0	0.000000		99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	79,902,398	501,724,165			200.00
201.00	Less Observation Beds	4,879,425	0			201.00
202.00	Total (line 200 minus line 201)	75,022,973	501,724,165			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part I Date/Time Prepared: 11/28/2017 11:20 am
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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	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,826,409	0	1,826,409	41,482	44.03	30.00
31.00	INTENSIVE CARE UNIT	498,596		498,596	4,551	109.56	31.00
41.00	SUBPROVIDER - IRF	218,845	0	218,845	3,573	61.25	41.00
43.00	NURSERY	0		0	780	0.00	43.00
200.00	Total (lines 30-199)	2,543,850		2,543,850	50,386		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	11,688	514,623				
31.00	INTENSIVE CARE UNIT	1,986	217,586				
41.00	SUBPROVIDER - IRF	1,468	89,915				
43.00	NURSERY	0	0				
200.00	Total (lines 30-199)	15,142	822,124				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part II
Date/Time Prepared:
11/28/2017 11:20 am

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	818,938	36,125,255	0.022669	7,340,921	166,411	50.00
51.00	05100	RECOVERY ROOM	46,200	5,061,765	0.009127	1,167,553	10,656	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	446,769	8,552,068	0.052241	15,858	828	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,424,959	24,438,403	0.058308	3,810,170	222,163	54.00
54.02	03630	ULTRA SOUND	35,320	15,394,638	0.002294	966,508	2,217	54.02
56.00	05600	RADIOISOTOPE	151,758	4,914,352	0.030881	807,571	24,939	56.00
57.00	05700	CT SCAN	320,743	57,741,884	0.005555	8,752,623	48,621	57.00
59.00	05900	CARDIAC CATHETERIZATION	45,249	3,926,814	0.011523	1,002,806	11,555	59.00
60.00	06000	LABORATORY	344,271	72,120,360	0.004774	15,625,402	74,596	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	180,842	23,576,481	0.007670	7,752,013	59,458	65.00
66.00	06600	PHYSICAL THERAPY	97,465	3,906,254	0.024951	574,155	14,326	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,533	3,974,957	0.011203	540,130	6,051	67.00
68.00	06800	SPEECH PATHOLOGY	33,347	1,853,619	0.017990	360,666	6,488	68.00
69.00	06900	ELECTROCARDIOLOGY	278,327	18,109,860	0.015369	5,397,161	82,949	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,682	540,203	0.067904	144,969	9,844	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	386,512	11,685,815	0.033075	3,786,120	125,226	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,115	6,067,362	0.024741	2,047,238	50,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,890	42,477,002	0.007225	11,565,684	83,562	73.00
74.00	07400	RENAL DIALYSIS	53,159	3,765,873	0.014116	1,576,765	22,258	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	897,378	148,058,319	0.006061	14,258,697	86,422	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	276,854	9,432,881	0.029350	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (Lines 50-199)	6,376,311	501,724,165		87,493,010	1,109,221	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part III Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description			Title XVIII				Hospital	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	PPS	
			1.00	2.00	3.00	4.00	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,482	0.00	11,688	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,551	0.00	1,986	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	3,573	0.00	1,468	0	0	41.00
43.00	04300	NURSERY	780	0.00	0	0	0	43.00
200.00		Total (lines 30-199)	50,386		15,142	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description		Title XVIII				Hospital		PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	03630	ULTRA SOUND	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description		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)	Hospital		Inpatient Program Charges	PPS
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)			
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	36,125,255	0.000000	0.000000	7,340,921	50.00
51.00	05100	RECOVERY ROOM	0	5,061,765	0.000000	0.000000	1,167,553	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,552,068	0.000000	0.000000	15,858	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,438,403	0.000000	0.000000	3,810,170	54.00
54.02	03630	ULTRA SOUND	0	15,394,638	0.000000	0.000000	966,508	54.02
56.00	05600	RADIOISOTOPE	0	4,914,352	0.000000	0.000000	807,571	56.00
57.00	05700	CT SCAN	0	57,741,884	0.000000	0.000000	8,752,623	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,926,814	0.000000	0.000000	1,002,806	59.00
60.00	06000	LABORATORY	0	72,120,360	0.000000	0.000000	15,625,402	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	23,576,481	0.000000	0.000000	7,752,013	65.00
66.00	06600	PHYSICAL THERAPY	0	3,906,254	0.000000	0.000000	574,155	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,974,957	0.000000	0.000000	540,130	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,853,619	0.000000	0.000000	360,666	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,109,860	0.000000	0.000000	5,397,161	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	540,203	0.000000	0.000000	144,969	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,685,815	0.000000	0.000000	3,786,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,067,362	0.000000	0.000000	2,047,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	42,477,002	0.000000	0.000000	11,565,684	73.00
74.00	07400	RENAL DIALYSIS	0	3,765,873	0.000000	0.000000	1,576,765	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	148,058,319	0.000000	0.000000	14,258,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	0	501,724,165			87,493,010	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
Title XVIII					
Hospital					
PPS					
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	3,365,421	0	50.00
51.00	05100 RECOVERY ROOM	0	573,301	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	2,070,084	0	54.00
54.02	03630 ULTRA SOUND	0	447,461	0	54.02
56.00	05600 RADIOISOTOPE	0	412,635	0	56.00
57.00	05700 CT SCAN	0	5,476,800	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	329,252	0	59.00
60.00	06000 LABORATORY	0	3,179,899	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	761,783	0	65.00
66.00	06600 PHYSICAL THERAPY	0	34,929	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	14,628	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	43,574	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,924,704	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	35,824	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	302,980	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	497,490	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1,752,714	0	73.00
74.00	07400 RENAL DIALYSIS	0	2,129	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	8,668,829	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2,011,364	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	0	31,905,801	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.224244	3,365,421	0	754,675	50.00
51.00	05100 RECOVERY ROOM	0.143810	573,301	0	82,446	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.474478	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.243246	2,070,084	0	503,540	54.00
54.02	03630 ULTRA SOUND	0.083777	447,461	0	37,487	54.02
56.00	05600 RADIOISOTOPE	0.220409	412,635	0	90,948	56.00
57.00	05700 CT SCAN	0.044808	5,476,800	0	245,404	57.00
59.00	05900 CARDIAC CATHETERIZATION	0.151495	329,252	0	49,880	59.00
60.00	06000 LABORATORY	0.108536	3,179,899	0	345,134	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.121598	761,783	0	92,631	65.00
66.00	06600 PHYSICAL THERAPY	0.415192	34,929	0	14,502	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273321	14,628	0	3,998	67.00
68.00	06800 SPEECH PATHOLOGY	0.313937	43,574	0	13,679	68.00
69.00	06900 ELECTROCARDIOLOGY	0.091735	1,924,704	0	176,563	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.451316	35,824	0	16,168	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.490160	302,980	0	148,509	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.366355	497,490	0	182,258	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205353	1,752,714	0	359,925	73.00
74.00	07400 RENAL DIALYSIS	0.309262	2,129	0	658	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0.000000	0	0	0	90.00
91.00	09100 EMERGENCY	0.114204	8,668,829	0	990,015	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.517278	2,011,364	0	1,040,434	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0		94.00
200.00	Subtotal (see instructions)		31,905,801	0	5,148,854	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		31,905,801	0	5,148,854	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.02	03630 ULTRA SOUND	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/28/2017 11:20 am		
				Title XVIII	Subprovider - IRF	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	818,938	36,125,255	0.022669	61,054	1,384	50.00
51.00	05100	RECOVERY ROOM	46,200	5,061,765	0.009127	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	446,769	8,552,068	0.052241	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,424,959	24,438,403	0.058308	57,367	3,345	54.00
54.02	03630	ULTRA SOUND	35,320	15,394,638	0.002294	33,606	77	54.02
56.00	05600	RADIOISOTOPE	151,758	4,914,352	0.030881	2,713	84	56.00
57.00	05700	CT SCAN	320,743	57,741,884	0.005555	86,141	479	57.00
59.00	05900	CARDIAC CATHETERIZATION	45,249	3,926,814	0.011523	13,726	158	59.00
60.00	06000	LABORATORY	344,271	72,120,360	0.004774	349,213	1,667	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	180,842	23,576,481	0.007670	292,085	2,240	65.00
66.00	06600	PHYSICAL THERAPY	97,465	3,906,254	0.024951	776,182	19,367	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,533	3,974,957	0.011203	832,460	9,326	67.00
68.00	06800	SPEECH PATHOLOGY	33,347	1,853,619	0.017990	231,532	4,165	68.00
69.00	06900	ELECTROCARDIOLOGY	278,327	18,109,860	0.015369	67,437	1,036	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,682	540,203	0.067904	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	386,512	11,685,815	0.033075	133,408	4,412	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,115	6,067,362	0.024741	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,890	42,477,002	0.007225	597,395	4,316	73.00
74.00	07400	RENAL DIALYSIS	53,159	3,765,873	0.014116	135,166	1,908	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	897,378	148,058,319	0.006061	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	6,099,457	501,724,165		3,669,485	53,964	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02 03630 ULTRA SOUND	0	0	0	0	0	54.02
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 + col. 7)	
	6.00	7.00	8.00	9.00	10.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	36,125,255	0.000000	0.000000	61,054 50.00
51.00 05100 RECOVERY ROOM	0	5,061,765	0.000000	0.000000	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	8,552,068	0.000000	0.000000	0 52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	24,438,403	0.000000	0.000000	57,367 54.00
54.02 03630 ULTRA SOUND	0	15,394,638	0.000000	0.000000	33,606 54.02
56.00 05600 RADIOISOTOPE	0	4,914,352	0.000000	0.000000	2,713 56.00
57.00 05700 CT SCAN	0	57,741,884	0.000000	0.000000	86,141 57.00
59.00 05900 CARDIAC CATHETERIZATION	0	3,926,814	0.000000	0.000000	13,726 59.00
60.00 06000 LABORATORY	0	72,120,360	0.000000	0.000000	349,213 60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0 62.30
65.00 06500 RESPIRATORY THERAPY	0	23,576,481	0.000000	0.000000	292,085 65.00
66.00 06600 PHYSICAL THERAPY	0	3,906,254	0.000000	0.000000	776,182 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	3,974,957	0.000000	0.000000	832,460 67.00
68.00 06800 SPEECH PATHOLOGY	0	1,853,619	0.000000	0.000000	231,532 68.00
69.00 06900 ELECTROCARDIOLOGY	0	18,109,860	0.000000	0.000000	67,437 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	540,203	0.000000	0.000000	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,685,815	0.000000	0.000000	133,408 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	6,067,362	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	42,477,002	0.000000	0.000000	597,395 73.00
74.00 07400 RENAL DIALYSIS	0	3,765,873	0.000000	0.000000	135,166 74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0 76.97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0.000000	0 76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0 76.99
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0.000000	0.000000	0 90.00
91.00 09100 EMERGENCY	0	148,058,319	0.000000	0.000000	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	0.000000	0.000000	0 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0 94.00
200.00 Total (lines 50-199)	0	501,724,165			3,669,485 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.02	03630 ULTRA SOUND	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part I Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,826,409	0	1,826,409	41,482	44.03	30.00
31.00	INTENSIVE CARE UNIT	498,596		498,596	4,551	109.56	31.00
41.00	SUBPROVIDER - IRF	218,845	0	218,845	3,573	61.25	41.00
43.00	NURSERY	0		0	780	0.00	43.00
200.00	Total (lines 30-199)	2,543,850		2,543,850	50,386		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,819	124,121				
31.00	INTENSIVE CARE UNIT	327	35,826				
41.00	SUBPROVIDER - IRF	105	6,431				
43.00	NURSERY	386	0				
200.00	Total (lines 30-199)	3,637	166,378				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part II
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		Title XIX			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	818,938	36,125,255	0.022669	0	0 50.00
51.00	05100	RECOVERY ROOM	46,200	5,061,765	0.009127	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	446,769	8,552,068	0.052241	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,424,959	24,438,403	0.058308	0	0 54.00
54.02	03630	ULTRA SOUND	35,320	15,394,638	0.002294	0	0 54.02
56.00	05600	RADIOISOTOPE	151,758	4,914,352	0.030881	0	0 56.00
57.00	05700	CT SCAN	320,743	57,741,884	0.005555	0	0 57.00
59.00	05900	CARDIAC CATHETERIZATION	45,249	3,926,814	0.011523	0	0 59.00
60.00	06000	LABORATORY	344,271	72,120,360	0.004774	0	0 60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	180,842	23,576,481	0.007670	0	0 65.00
66.00	06600	PHYSICAL THERAPY	97,465	3,906,254	0.024951	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	44,533	3,974,957	0.011203	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	33,347	1,853,619	0.017990	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	278,327	18,109,860	0.015369	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,682	540,203	0.067904	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	386,512	11,685,815	0.033075	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,115	6,067,362	0.024741	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,890	42,477,002	0.007225	0	0 73.00
74.00	07400	RENAL DIALYSIS	53,159	3,765,873	0.014116	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
91.00	09100	EMERGENCY	897,378	148,058,319	0.006061	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	276,854	9,432,881	0.029350	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0 94.00
200.00		Total (lines 50-199)	6,376,311	501,724,165		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part III Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description			Title XIX				Hospital	
			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	PPS	
			1.00	2.00	3.00	4.00	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,482	0.00	2,819	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,551	0.00	327	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	3,573	0.00	105	0	0	41.00
43.00	04300	NURSERY	780	0.00	386	0	0	43.00
200.00		Total (lines 30-199)	50,386		3,637	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description	Title XIX			Hospital	PPS	Total Cost (sum of col 1 through col 4)
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02 03630 ULTRA SOUND	0	0	0	0	0	54.02
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description		Title XIX			Hospital		PPS
		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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	36,125,255	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	5,061,765	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8,552,068	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	24,438,403	0.000000	0.000000	0	54.00
54.02	03630 ULTRA SOUND	0	15,394,638	0.000000	0.000000	0	54.02
56.00	05600 RADIOISOTOPE	0	4,914,352	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	57,741,884	0.000000	0.000000	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,926,814	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	72,120,360	0.000000	0.000000	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	23,576,481	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	3,906,254	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,974,957	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,853,619	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	18,109,860	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	540,203	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,685,815	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6,067,362	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	42,477,002	0.000000	0.000000	0	73.00
74.00	07400 RENAL DIALYSIS	0	3,765,873	0.000000	0.000000	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	148,058,319	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00	Total (lines 50-199)	0	501,724,165			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet D
Part IV
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		Title XIX			Hospital	PPS
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.02	03630 ULTRA SOUND	0	0	0		54.02
56.00	05600 RADIOISOTOPE	0	0	0		56.00
57.00	05700 CT SCAN	0	0	0		57.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0		62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699 LI THOTRI PSY	0	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0		90.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0		94.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/28/2017 11:20 am
Title XIX			Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	818,938	36,125,255	0.022669	0	50.00
51.00	05100	RECOVERY ROOM	46,200	5,061,765	0.009127	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	446,769	8,552,068	0.052241	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,424,959	24,438,403	0.058308	0	54.00
54.02	03630	ULTRA SOUND	35,320	15,394,638	0.002294	0	54.02
56.00	05600	RADIOISOTOPE	151,758	4,914,352	0.030881	0	56.00
57.00	05700	CT SCAN	320,743	57,741,884	0.005555	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	45,249	3,926,814	0.011523	0	59.00
60.00	06000	LABORATORY	344,271	72,120,360	0.004774	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	180,842	23,576,481	0.007670	0	65.00
66.00	06600	PHYSICAL THERAPY	97,465	3,906,254	0.024951	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,533	3,974,957	0.011203	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,347	1,853,619	0.017990	0	68.00
69.00	06900	ELECTROCARDIOLOGY	278,327	18,109,860	0.015369	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,682	540,203	0.067904	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	386,512	11,685,815	0.033075	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	150,115	6,067,362	0.024741	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,890	42,477,002	0.007225	0	73.00
74.00	07400	RENAL DIALYSIS	53,159	3,765,873	0.014116	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	90.00
91.00	09100	EMERGENCY	897,378	148,058,319	0.006061	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	94.00
200.00		Total (lines 50-199)	6,099,457	501,724,165		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	03630 ULTRA SOUND	0	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
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Cost Center Description		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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	36,125,255	0.000000	0.000000	0	50.00
51.00	05100 RECOVERY ROOM	0	5,061,765	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8,552,068	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	24,438,403	0.000000	0.000000	0	54.00
54.02	03630 ULTRA SOUND	0	15,394,638	0.000000	0.000000	0	54.02
56.00	05600 RADIOISOTOPE	0	4,914,352	0.000000	0.000000	0	56.00
57.00	05700 CT SCAN	0	57,741,884	0.000000	0.000000	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	3,926,814	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	72,120,360	0.000000	0.000000	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	23,576,481	0.000000	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0	3,906,254	0.000000	0.000000	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	3,974,957	0.000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,853,619	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	18,109,860	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	540,203	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11,685,815	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	6,067,362	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	42,477,002	0.000000	0.000000	0	73.00
74.00	07400 RENAL DIALYSIS	0	3,765,873	0.000000	0.000000	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	148,058,319	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,432,881	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00	Total (lines 50-199)	0	501,724,165			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/28/2017 11:20 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.02	03630 ULTRA SOUND	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Hospital	PPS
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		41,482	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		41,482	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)		35,194	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)		11,688	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)		32,189,709	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)		32,189,709	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)		32,189,709	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)		775.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,069,771	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)		9,069,771	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	8,324,734	4,551	1,829.21	1,986	3,632,811	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					14,346,697	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					27,049,279	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)					732,209	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,109,221	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,841,430	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					25,207,849	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)					6,288	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					775.99	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,879,425	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,826,409	32,189,709	0.056739	4,879,425	276,854	90.00
91.00	Nursing School cost	0	32,189,709	0.000000	4,879,425	0	91.00
92.00	Allied health cost	0	32,189,709	0.000000	4,879,425	0	92.00
93.00	All other Medical Education	0	32,189,709	0.000000	4,879,425	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,573 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,573 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)			3,573 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			1,468 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)			3,049,754 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)			3,049,754 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)			3,049,754 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)			853.56 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,253,026 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,253,026 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				968,952		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				2,221,978		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)				89,915		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				53,964		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				143,879		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				2,078,099		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
56.00	Target amount (line 54 x line 55)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	218,845	3,049,754	0.071758	0	0	90.00
91.00	Nursing School cost	0	3,049,754	0.000000	0	0	91.00
92.00	Allied health cost	0	3,049,754	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,049,754	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am
		Title XIX	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)		41,482	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		41,482	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)		35,194	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)		2,819	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)		780	15.00
16.00	Nursery days (title V or XIX only)		386	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)		32,189,709	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)		32,189,709	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)		32,189,709	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)		775.99	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,187,516	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,187,516	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	PPS
42.00	NURSERY (title V & XIX only)	0	780	0.00	386	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,324,734	4,551	1,829.21	327	598,152	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,785,668	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)					159,947	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					159,947	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,625,721	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)					6,288	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					775.99	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,879,425	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet D-1

Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description	Cost	Title XIX		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	1,826,409	32,189,709	0.056739	4,879,425	276,854	90.00
91.00 Nursing School cost	0	32,189,709	0.000000	4,879,425	0	91.00
92.00 Allied health cost	0	32,189,709	0.000000	4,879,425	0	92.00
93.00 All other Medical Education	0	32,189,709	0.000000	4,879,425	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,573 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,573 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)			3,573 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)			105 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)			780 15.00
16.00	Nursery days (title V or XIX only)			386 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)			3,049,754 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)			3,049,754 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)			3,049,754 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)			853.56 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			89,624 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)			89,624 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				0		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				89,624		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)				6,431		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				0		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				6,431		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				83,193		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
56.00	Target amount (line 54 x line 55)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/28/2017 11:20 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	218,845	3,049,754	0.071758	0	0	90.00
91.00	Nursing School cost	0	3,049,754	0.000000	0	0	91.00
92.00	Allied health cost	0	3,049,754	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,049,754	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 11:20 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		26,913,461	30.00
31.00	03100	INTENSIVE CARE UNIT		8,217,478	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.224244	7,340,921	50.00
51.00	05100	RECOVERY ROOM	0.143810	1,167,553	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.474478	15,858	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.243246	3,810,170	54.00
54.02	03630	ULTRA SOUND	0.083777	966,508	54.02
56.00	05600	RADIOISOTOPE	0.220409	807,571	56.00
57.00	05700	CT SCAN	0.044808	8,752,623	57.00
59.00	05900	CARDIAC CATHETERIZATION	0.151495	1,002,806	59.00
60.00	06000	LABORATORY	0.108536	15,625,402	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.121598	7,752,013	65.00
66.00	06600	PHYSICAL THERAPY	0.415192	574,155	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273321	540,130	67.00
68.00	06800	SPEECH PATHOLOGY	0.313937	360,666	68.00
69.00	06900	ELECTROCARDIOLOGY	0.091735	5,397,161	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.451316	144,969	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.490160	3,786,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.366355	2,047,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.205353	11,565,684	73.00
74.00	07400	RENAL DIALYSIS	0.309262	1,576,765	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIpsy	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.114204	14,258,697	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.517278	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		87,493,010	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		87,493,010	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/28/2017 11:20 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		2,299,686		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.224244	61,054	13,691	50.00
51.00	05100 RECOVERY ROOM	0.143810	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.474478	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.243246	57,367	13,954	54.00
54.02	03630 ULTRA SOUND	0.083777	33,606	2,815	54.02
56.00	05600 RADIOISOTOPE	0.220409	2,713	598	56.00
57.00	05700 CT SCAN	0.044808	86,141	3,860	57.00
59.00	05900 CARDIAC CATHETERIZATION	0.151495	13,726	2,079	59.00
60.00	06000 LABORATORY	0.108536	349,213	37,902	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.121598	292,085	35,517	65.00
66.00	06600 PHYSICAL THERAPY	0.415192	776,182	322,265	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.273321	832,460	227,529	67.00
68.00	06800 SPEECH PATHOLOGY	0.313937	231,532	72,686	68.00
69.00	06900 ELECTROCARDIOLOGY	0.091735	67,437	6,186	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.451316	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.490160	133,408	65,391	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.366355	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.205353	597,395	122,677	73.00
74.00	07400 RENAL DIALYSIS	0.309262	135,166	41,802	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.114204	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.517278	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50-94 and 96-98)		3,669,485	968,952	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net Charges (line 200 minus line 201)		3,669,485		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	5,078,337		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	15,997,100		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)	168,513		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)	188.31		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 Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		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 section 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 section 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 Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 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)		14.31	30.00
31.00	Percentage of Medicaid patient days (see instructions)		43.81	31.00
32.00	Sum of lines 30 and 31		58.12	32.00
33.00	Allowable disproportionate share percentage (see instructions)		37.16	33.00
34.00	Disproportionate share adjustment (see instructions)		1,957,909	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 11:20 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00	
35.01	Factor 3 (see instructions)	0.000387068	0.000406210	35.01	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,479,614	2,428,113	35.02	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	623,291	1,816,095	35.03	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,439,386		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)	2,648		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)	388	0	41.00	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	388	0	41.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	14.65		42.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	2,098		43.00	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.772459		44.00	
45.00	Average weekly cost for dialysis treatments (see instructions)	447.81	0.00	45.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)	134,213		46.00	
47.00	Subtotal (see instructions)	25,775,458		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)		25,775,458	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,916,720	50.00	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00	
53.00	Nursing and Allied Health Managed Care payment		0	53.00	
54.00	Special add-on payments for new technologies		0	54.00	
54.01	Islet isolation add-on payment		0	54.01	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00	
59.00	Total (sum of amounts on lines 49 through 58)		27,692,178	59.00	
60.00	Primary payer payments		0	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		27,692,178	61.00	
62.00	Deductibles billed to program beneficiaries		2,223,101	62.00	
63.00	Coinurance billed to program beneficiaries		150,213	63.00	
64.00	Allowable bad debts (see instructions)		845,111	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)		549,322	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		845,111	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		25,868,186	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 DEMONSTRATION PROJECT		0	70.50	
70.88	SCH or MDH volume decrease adjustment		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)		-58,031	70.93	
70.94	HRR adjustment amount (see instructions)		-274,980	70.94	
70.95	Recovery of accelerated depreciation		0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/28/2017 11:20 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	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)			25,535,175	71.00
71.01	Sequestration adjustment (see instructions)			510,704	71.01
72.00	Interim payments			24,553,307	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, 72, and 73)			471,164	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,148,854	2.00
3.00	PPS payments		3,935,761	3.00
4.00	Outlier payment (see instructions)		10,009	4.00
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 line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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 (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		3,945,770	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)		836,813	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)		3,108,957	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)		3,108,957	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		3,108,957	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)		318,634	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		207,112	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		316,838	36.00
37.00	Subtotal (see instructions)		3,316,069	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
39.98	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)		3,316,069	40.00
40.01	Sequestration adjustment (see instructions)		66,321	40.01
41.00	Interim payments		3,335,701	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-85,953	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: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2017 11:20 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		24,519,945		3,240,040		1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	02/02/2017	33,362	02/02/2017	95,661		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)		33,362		95,661		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)		24,553,307		3,335,701		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		471,164		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		85,953		6.02
7.00	Total Medicare program liability (see instructions)		25,024,471		3,249,748		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0133
Component CCN: 14-T133

Period:
From 07/01/2016
To 06/30/2017

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2017 11:20 am
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,398,881		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/02/2017	19,398		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)		19,398		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,418,279		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		54,333		0	6.02
7.00	Total Medicare program liability (see instructions)		2,363,946		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part III Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			2,186,104 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0520 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			229,541 3.00
4.00	Outlier Payments			6,666 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			9.789041 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			2,422,311 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			2,422,311 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			2,422,311 19.00
20.00	Deductibles			5,208 20.00
21.00	Subtotal (line 19 minus line 20)			2,417,103 21.00
22.00	Coinsurance			5,264 22.00
23.00	Subtotal (line 21 minus line 22)			2,411,839 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			540 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			351 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			540 26.00
27.00	Subtotal (sum of lines 23 and 25)			2,412,190 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			2,412,190 32.00
32.01	Sequestration adjustment (see instructions)			48,244 32.01
33.00	Interim payments			2,418,279 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)			-54,333 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			6,666 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 14-0133 Period: From 07/01/2016 To 06/30/2017 Worksheet G Date/Time Prepared: 11/28/2017 11:20 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	14,657,272	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	42,740,581	0	0	0	4.00
5.00	Other receivable	2,968,029	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-18,900,223	0	0	0	6.00
7.00	Inventory	2,059,078	0	0	0	7.00
8.00	Prepaid expenses	1,729,948	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	8,854,745	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	54,109,430	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,700,000	0	0	0	12.00
13.00	Land improvements	707,906	0	0	0	13.00
14.00	Accumulated depreciation	-172,411	0	0	0	14.00
15.00	Buildings	96,330,170	0	0	0	15.00
16.00	Accumulated depreciation	-16,120,633	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	30,434,939	0	0	0	23.00
24.00	Accumulated depreciation	-19,149,220	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)	93,730,751	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	11,528,967	0	0	0	31.00
32.00	Deposits on leases	64,272	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,593,239	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	159,433,420	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	12,030,481	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,323,032	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	5,634,245	0	0	0	43.00
44.00	Other current liabilities	7,031,876	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	30,019,634	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	15,054,865	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)	15,054,865	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	45,074,499	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	114,358,921	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	114,358,921	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	159,433,420	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-1

Date/Time Prepared:
11/28/2017 11:20 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		119,080,556		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-4,721,635				2.00
3.00	Total (sum of line 1 and line 2)		114,358,921		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		114,358,921		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)		114,358,921		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	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: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2017 11:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	70,475,469		70,475,469	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	5,530,345		5,530,345	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)	76,005,814		76,005,814	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,405,730		21,405,730	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	21,405,730		21,405,730	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	97,411,544		97,411,544	17.00
18.00	Ancillary services	256,965,047	1	256,965,048	18.00
19.00	Outpatient services	0	249,812,667	249,812,667	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
24.20	OPT	0	0	0	24.20
24.30	OOT	0	0	0	24.30
24.40	OSP	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	354,376,591	249,812,668	604,189,259	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		126,344,734		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)		126,344,734		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0133

Period:
From 07/01/2016
To 06/30/2017

Worksheet G-3

Date/Time Prepared:
11/28/2017 11:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	604,189,259	1.00
2.00	Less contractual allowances and discounts on patients' accounts	473,969,132	2.00
3.00	Net patient revenues (line 1 minus line 2)	130,220,127	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	126,344,734	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,875,393	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,500	6.00
7.00	Income from investments	2,138,120	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	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ALL OTHER INCOME	2,581,324	24.00
25.00	Total other income (sum of lines 6-24)	4,720,944	25.00
26.00	Total (line 5 plus line 25)	8,596,337	26.00
27.00	BAD DEBT	13,317,972	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	13,317,972	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,721,635	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0133	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/28/2017 11:20 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,695,324	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		9,650	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)		109.08	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)		14.31	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		43.81	8.00
9.00	Sum of lines 7 and 8		58.12	9.00
10.00	Allowable disproportionate share percentage (see instructions)		12.49	10.00
11.00	Disproportionate share adjustment (see instructions)		211,746	11.00
12.00	Total prospective capital payments (see instructions)		1,916,720	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