

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: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/26/2019 8:45 pm
--	-----------------------	---------------------------------------	---

PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 2/26/2019 Time: 8:45 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only 5. Cost Report Status 6. Date Received: 10. NPR Date:
 (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
 (2) Settled without Audit 8. Initial Report for this Provider CCN 12. If line 5, column 1 is 4: Enter
 (3) Settled with Audit 9. Final Report for this Provider CCN number of times reopened = 0-9.
 (4) Reopened
 (5) Amended

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF SAINT ANTHONY'S HEALTH CENTER (14-0052) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

 Title

 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	91,826	37,024	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	91,826	37,024	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: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 8:45 pm
---	--	-----------------------	---	---

1.00	2.00	3.00	4.00	1.00	2.00
Hospital and Hospital Health Care Complex Address:					
Street: SAINT ANTHONY'S WAY		PO Box: 340	Zip Code: 62002-0340	County: MADISON	
City: ALTON		State: IL			

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	OSF SAINT ANTHONY'S HEALTH CENTER	140052	41180	1	07/01/1966	N	P	0	3.00
4.00	Subprovider - IPF	SAINT ANTHONY'S COMPREHENSIVE REHAB	14T052	41180	5	01/01/1993	N	P	0	4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SAINT ANTHONY'S SKILLED NURSING	145314	41180		11/01/1975	N	P	0	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2017		09/30/2018		20.00
21.00	Type of Control (see instructions)					1				21.00

	1.00	2.00	3.00	
--	------	------	------	--

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		N	22.03
23.00	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.									
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052			Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 8:45 pm			
		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.	560	564	0	0	1,755	26		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.	0	0	0	0	0			25.00	
						Urban/Rural	S	Date of Geogr		
						1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					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)								37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00	
						Y/N	Y/N			
						1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00	
						V	XVIII	XIX		
						1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N		48.00
Teaching Hospitals										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.									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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 8:45 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00		61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovi der Site	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 8:45 pm	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 8:45 pm			
						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00	
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00	
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						Y	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.					N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.					N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.					0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.02	
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.03	
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	N	98.04	
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.05	
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					N	Y	98.06	
Rural Providers									
105.00	Does this hospital qualify as a CAH?					N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)							106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.					N		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
						1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.						N		110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 8:45 pm	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	612,137	314,233		0118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		149006	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/26/2019 8:45 pm			
1.00	2.00	3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: OSF HEALTHCARE SYSTEM	Contractor's Name: NGS		Contractor's Number: 06101			
142.00	Street: 800 NE GLEN OAK AVENUE	PO Box:					
143.00	City: PEORIA	State: IL	Zip Code: 61603				
144.00 Are provider based physicians' costs included in Worksheet A?							
				1.00	144.00		
				Y			
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.							
				1.00	2.00		
				N	145.00		
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							
				1.00	146.00		
				N			
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
				1.00	147.00		
				N			
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
				1.00	148.00		
				N			
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
				1.00	149.00		
				N			
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)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
165.00 Multi campus							
Enter "Y" for yes or "N" for no.				1.00	165.00		
				N			
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)							
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
							0.00
167.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				1.00	167.00		
				Y			
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)							
				1.00	168.00		
				0			
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)							
				1.00	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)							
				1.00	169.00		
				9.99			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
		1.00	2.00				
				10/01/2017	09/30/2018		
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)							
				1.00	171.00		
				N			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part II Date/Time Prepared: 2/26/2019 8:45 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		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)	Y					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	01/21/2019			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					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			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)	Y	12/18/2018	Y	12/18/2018		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: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/26/2019 8:45 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	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.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			Y	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	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.			N	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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	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.			N	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.			N	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.			Y	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.			N	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		Y		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.	LOUIS		RAPTOPOULOS	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF SAINT ANTHONY'S HEALTH CENTER			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309-624-9230		LOUIS.C.RAPTOPOULOS@OSFHEALTHCARE. OR	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/26/2019 8:45 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	GOVT REPORTING SR ANALYST		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: 14-0052

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	68	24,820	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)		68	24,820	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	10	3,650	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)		78	28,470	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		78				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)		7	2,555			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0052

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	4,420	459	9,241			1.00
2.00 HMO and other (see instructions)	1,836	2,319				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	4,420	459	9,241			7.00
8.00 INTENSIVE CARE UNIT	491	81	1,612			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		20	402			13.00
14.00 Total (see instructions)	4,911	560	11,255	0.00	450.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	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			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	450.00	27.00
28.00 Observation Bed Days		664	1,274			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	26	44			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0052

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

Worksheet S-3
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,229	250	3,625	1.00
2.00 HMO and other (see instructions)			453	713		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,229	250	3,625	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet S-3 Part II Date/Time Prepared: 2/26/2019 8:45 pm	
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	26,124,660	-41,939	26,082,721	920,285.00	28.34	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		5,536	0	5,536	36.00	153.78	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		59,812	-1,963	57,849	2,075.00	27.88	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		597,703	0	597,703	7,808.00	76.55	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		46,200	0	46,200	389.00	118.77	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		5,954,525	0	5,954,525	160,502.00	37.10	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		7,812,285	0	7,812,285			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		17,543	0	17,543			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		849	0	849			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,866,270	0	1,866,270			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	18,773	0	18,773	362.00	51.86	26.00
27.00	Administrative & General	5.00	2,861,785	18,576	2,880,361	78,519.00	36.68	27.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0052

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

Worksheet S-3
Part II
Date/Time Prepared:
2/26/2019 8:45 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	451,515	0	451,515	3,647.00	123.80	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,160,956	47,798	1,208,754	53,837.00	22.45	30.00
31.00	Laundry & Linen Service	30,765	0	30,765	2,827.00	10.88	31.00
32.00	Housekeeping	791,988	24,111	816,099	56,968.00	14.33	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	340,065	24,768	364,833	19,353.00	18.85	34.00
35.00	Dietary under contract (see instructions)	0	0	0	0.00	0.00	35.00
36.00	Cafeteria	604,682	-117,647	487,035	30,880.00	15.77	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	841,140	-582	840,558	20,618.00	40.77	38.00
39.00	Central Services and Supply	329,936	9,659	339,595	21,767.00	15.60	39.00
40.00	Pharmacy	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	626,834	0	626,834	26,480.00	23.67	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0052

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

Worksheet S-3
Part III
Date/Time Prepared:
2/26/2019 8:45 pm

	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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	26,576,175	-41,939	26,534,236	923,932.00	28.72	1.00
2.00	Excluded area salaries (see instructions)	59,812	-1,963	57,849	2,075.00	27.88	2.00
3.00	Subtotal salaries (line 1 minus line 2)	26,516,363	-39,976	26,476,387	921,857.00	28.72	3.00
4.00	Subtotal other wages & related costs (see inst.)	6,598,428	0	6,598,428	168,699.00	39.11	4.00
5.00	Subtotal wage-related costs (see inst.)	9,679,404	0	9,679,404	0.00	36.56	5.00
6.00	Total (sum of lines 3 thru 5)	42,794,195	-39,976	42,754,219	1,090,556.00	39.20	6.00
7.00	Total overhead cost (see instructions)	8,058,439	6,683	8,065,122	315,258.00	25.58	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2019 8:45 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		930,260	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)		795,689	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		4,339,112	8.02
8.03	Health Insurance (Purchased)		0	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		41,939	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		228,516	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		1,414,650	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		0	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		80,511	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		7,830,677	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: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part V Date/Time Prepared: 2/26/2019 8:45 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		597,703	7,830,677
2.00	Hospital		597,703	0
3.00	Subprovider - IPF			0
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF		0	0
9.00	Hospital-Based NF			0
10.00	Hospital-Based OLTC			0
11.00	Hospital-Based HHA			0
12.00	Separately Certified ASC			0
13.00	Hospital-Based Hospice			0
14.00	Hospital-Based Health Clinic RHC			0
15.00	Hospital-Based Health Clinic FQHC			0
16.00	Hospital-Based-CMHC			0
17.00	Renal Dialysis			0
18.00	Other		0	7,830,677

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0052

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

Worksheet S-7

Date/Time Prepared:
2/26/2019 8:45 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.				1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.				2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	0	0	0 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	0	0	0 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	0	0	0 15.00
16.00		RVB	0	0	0 16.00
17.00		RVA	0	0	0 17.00
18.00		RHC	0	0	0 18.00
19.00		RHB	0	0	0 19.00
20.00		RHA	0	0	0 20.00
21.00		RMC	0	0	0 21.00
22.00		RMB	0	0	0 22.00
23.00		RMA	0	0	0 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	0	0	0 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	0	0	0 33.00
34.00		HC1	0	0	0 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	0	0	0 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	0	0	0 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	0	0	0 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	0	0	0 50.00
51.00		CB2	0	0	0 51.00
52.00		CB1	0	0	0 52.00
53.00		CA2	0	0	0 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0052

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

Worksheet S-7

Date/Time Prepared:
2/26/2019 8:45 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

201.00 SNF SERVICES
Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable). 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	145,314		207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/26/2019 8:45 pm
---	-----------------------	---	--

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.181507	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		12,596,281	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		99,329,494	6.00
7.00	Medicaid cost (line 1 times line 6)		18,028,998	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)		5,432,717	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)		5,432,717	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)	5,139,248	754,122	5,893,370
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	932,809	754,122	1,686,931
22.00	Payments received from patients for amounts previously written off as charity care	39,745	0	39,745
23.00	Cost of charity care (line 21 minus line 22)	893,064	754,122	1,647,186
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		6,253,004	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		579,614	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		891,714	27.01
28.00	Non-Medicare bad debt expense (see instructions)		5,361,290	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,285,212	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,932,398	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,365,115	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0052

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

Worksheet A
Date/Time Prepared:
2/26/2019 8:45 pm

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		2,840,469	2,840,469	-1,066,413	1,774,056	1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT		0	0	820,196	820,196	1.01
1.02 00102 CAP REL COSTS-BLDG & FIXT		0	0	56,440	56,440	1.02
1.03 00103 CAP REL COSTS-BLDG & FIXT		0	0	224,534	224,534	1.03
1.04 00104 CAP REL COSTS-BLDG & FIXT		0	0	49,043	49,043	1.04
2.00 00200 CAP REL COSTS-MVBLE EQUIP		1,461,391	1,461,391	-168,065	1,293,326	2.00
2.01 00201 CAP REL COSTS-MVBLE EQUIP		0	0	205,284	205,284	2.01
2.02 00202 CAP REL COSTS-MVBLE EQUIP		0	0	1,580	1,580	2.02
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	18,773	7,647,977	7,666,750	1,301,051	8,967,801	4.00
5.01 00540 NONPATIENT TELEPHONES	563,189	38,542	601,731	18,576	620,307	5.01
5.02 00560 PURCHASING RECEIVING AND STORES	174,366	19,136	193,502	0	193,502	5.02
5.04 00580 CASHIERING/ACCOUNTS RECEIVABLE	14,338	60,862	75,200	0	75,200	5.04
5.05 00590 OTHER ADMINISTRATIVE AND GENERAL	2,109,892	20,142,855	22,252,747	-2,415,646	19,837,101	5.05
7.00 00700 OPERATION OF PLANT	1,160,956	2,912,768	4,073,724	-303,413	3,770,311	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	30,765	264,942	295,707	0	295,707	8.00
9.00 00900 HOUSEKEEPING	791,988	269,655	1,061,643	24,767	1,086,410	9.00
10.00 01000 DIETARY	340,065	96,137	436,202	24,768	460,970	10.00
11.00 01100 CAFETERIA	604,682	473,969	1,078,651	-117,647	961,004	11.00
13.00 01300 NURSING ADMINISTRATION	841,140	187,401	1,028,541	976	1,029,517	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	329,936	119,453	449,389	-16,608	432,781	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	626,834	183,033	809,867	0	809,867	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	601,751	601,751	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	3,147,847	1,585,528	4,733,375	2,162	4,735,537	30.00
31.00 03100 INTENSIVE CARE UNIT	1,223,042	577,172	1,800,214	-21,940	1,778,274	31.00
41.00 04100 SUBPROVIDER - IRF	6,298	524	6,822	0	6,822	41.00
43.00 04300 NURSERY	0	419,373	419,373	273,100	692,473	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2,564,064	3,384,971	5,949,035	-2,812,955	3,136,080	50.00
51.00 05100 RECOVERY ROOM	324,787	38,350	363,137	10,157	373,294	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	972,711	232,660	1,205,371	-273,100	932,271	52.00
53.00 05300 ANESTHESIOLOGY	0	869,625	869,625	0	869,625	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,862,099	628,854	2,490,953	438,132	2,929,085	54.00
57.00 05700 CT SCAN	164,231	265,908	430,139	2,193	432,332	57.00
58.00 05800 MRI	114,912	32,179	147,091	16,891	163,982	58.00
59.00 05900 CARDIAC CATHETERIZATION	324,157	955,164	1,279,321	-804,455	474,866	59.00
60.00 06000 LABORATORY	1,633,117	2,154,265	3,787,382	71,603	3,858,985	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	210,810	210,810	0	210,810	62.00
64.00 06400 INTRAVENOUS THERAPY	404,094	76,418	480,512	-19,109	461,403	64.00
65.00 06500 RESPIRATORY THERAPY	576,305	130,691	706,996	-90,787	616,209	65.00
66.00 06600 PHYSICAL THERAPY	875,515	26,287	901,802	-3,305	898,497	66.00
67.00 06700 OCCUPATIONAL THERAPY	360,657	4,589	365,246	38,429	403,675	67.00
68.00 06800 SPEECH PATHOLOGY	179,022	992	180,014	47,522	227,536	68.00
69.00 06900 ELECTROCARDIOLOGY	298,141	90,319	388,460	-52,876	335,584	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	65,681	257,481	323,162	8,445	331,607	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	-65,981	-65,981	2,024,382	1,958,401	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,751,179	1,751,179	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	879,346	6,897,399	7,776,745	118,544	7,895,289	73.00
76.00 03950 THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	480,314	9,276	489,590	0	489,590	76.03
76.04 03952 PAIN CLINIC	75,746	12,212	87,958	17,165	105,123	76.04
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	1,932,136	650,489	2,582,625	10,140	2,592,765	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE		-7,309	-7,309	7,309	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	26,071,146	56,156,836	82,227,982	0	82,227,982	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	885	885	0	885	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	273,223	273,223	0	273,223	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.02 19302 FUND DEVELOPMENT	0	254,609	254,609	0	254,609	193.02
193.05 19305 EMS	54,127	43,921	98,048	0	98,048	193.05
193.07 19307 SAINT CLARE'S VILLA	-613	4,031	3,418	0	3,418	193.07
194.00 07950 UNUSED SPACE	0	0	0	0	0	194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	26,124,660	56,733,505	82,858,165	0	82,858,165	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0052

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

Worksheet A
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	720,148	2,494,204	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	820,196	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT	0	56,440	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT	0	224,534	1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT	0	49,043	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	389,977	1,683,303	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP	0	205,284	2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP	0	1,580	2.02
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-941	8,966,860	4.00
5.01	00540	NONPATIENT TELEPHONES	0	620,307	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	193,502	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	75,200	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-7,497,716	12,339,385	5.05
7.00	00700	OPERATION OF PLANT	0	3,770,311	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	295,707	8.00
9.00	00900	HOUSEKEEPING	0	1,086,410	9.00
10.00	01000	DIETARY	-25,416	435,554	10.00
11.00	01100	CAFETERIA	-373,282	587,722	11.00
13.00	01300	NURSING ADMINISTRATION	238,801	1,268,318	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	432,781	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-148	809,719	16.00
17.00	01700	SOCIAL SERVICE	-149,267	452,484	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,093,463	3,642,074	30.00
31.00	03100	INTENSIVE CARE UNIT	-243,956	1,534,318	31.00
41.00	04100	SUBPROVIDER - IRF	0	6,822	41.00
43.00	04300	NURSERY	-355,130	337,343	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-3	3,136,077	50.00
51.00	05100	RECOVERY ROOM	-500	372,794	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-900	931,371	52.00
53.00	05300	ANESTHESIOLOGY	-814,000	55,625	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,086	2,925,999	54.00
57.00	05700	CT SCAN	-1,222	431,110	57.00
58.00	05800	MRI	0	163,982	58.00
59.00	05900	CARDIAC CATHETERIZATION	-100,000	374,866	59.00
60.00	06000	LABORATORY	-46,309	3,812,676	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	210,810	62.00
64.00	06400	INTRAVENOUS THERAPY	-150	461,253	64.00
65.00	06500	RESPIRATORY THERAPY	0	616,209	65.00
66.00	06600	PHYSICAL THERAPY	-585	897,912	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	403,675	67.00
68.00	06800	SPEECH PATHOLOGY	0	227,536	68.00
69.00	06900	ELECTROCARDIOLOGY	-74,289	261,295	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-44,116	287,491	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,958,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,751,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-144,905	7,750,384	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-21,038	468,552	76.03
76.04	03952	PAIN CLINIC	0	105,123	76.04
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	-274,545	2,318,220	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,916,041	72,311,941	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	885	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	273,223	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	254,609	193.02
193.05	19305	EMS	0	98,048	193.05
193.07	19307	SAINT CLARE'S VILLA	0	3,418	193.07
194.00	07950	UNUSED SPACE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,916,041	72,942,124	200.00

RECLASSIFICATIONS

Provider CCN: 14-0052

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

Worksheet A-6
Date/Time Prepared:
2/26/2019 8:45 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
A - RECLASS SHORT TERM DISABILITY					
1.00	OPERATION OF PLANT	7.00	0	1,738	1.00
2.00	HOUSEKEEPING	9.00	0	656	2.00
3.00	NURSING ADMINISTRATION	13.00	0	1,558	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	498	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	14,393	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	9,530	6.00
7.00	SUBPROVIDER - IRF	41.00	0	9	7.00
8.00	OPERATING ROOM	50.00	0	3,117	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,958	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,785	10.00
11.00	LABORATORY	60.00	0	184	11.00
12.00	INTRAVENOUS THERAPY	64.00	0	681	12.00
13.00	EMERGENCY	91.00	0	1,878	13.00
14.00	SAINT CLARE'S VILLA	193.07	0	1,954	14.00
	0		0	41,939	
B - TO RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	129,908	1.00
2.00		0.00	0	0	2.00
	0		0	129,908	
C - TO RECLASS REHAB ADMINISTRATION					
1.00	OCCUPATIONAL THERAPY	67.00	17,054	515	1.00
2.00	SPEECH PATHOLOGY	68.00	36,150	1,091	2.00
	TOTALS		53,204	1,606	
D - TO RECLASS INTEREST EXPENSE					
1.00		0.00	0	0	1.00
2.00	INTEREST EXPENSE	113.00	0	7,309	2.00
	TOTALS		0	7,309	
E - MINISTRY COST ALLOCATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,301,051	1.00
2.00	OPERATION OF PLANT	7.00	0	197,069	2.00
3.00	SOCIAL SERVICE	17.00	0	601,751	3.00
5.00	PHYSICAL THERAPY	66.00	0	51,505	5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	20,860	6.00
7.00	SPEECH PATHOLOGY	68.00	0	10,281	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	103,221	8.00
	TOTALS		0	2,285,738	
F - RECLASS CANCER NAVIGATOR					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	19,109	0	1.00
	0		19,109	0	
G - RECLASS MEDICAL BILLABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	2,024,382	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
	0		0	2,024,382	
H - TO RECLASS IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,751,179	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
	0		0	1,751,179	
I - RECLASS DEPRECIATION EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.01	0	809,640	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.02	0	54,413	2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.03	0	216,632	3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.04	0	46,594	4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2.01	0	196,238	5.00
6.00	CAP REL COSTS-MVBLE EQUIP	2.02	0	1,441	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
	0		0	1,324,958	
J - RECLASS OF IMAGING MGR AND SPRVSR					
1.00	ELECTROENCEPHALOGRAPHY	70.00	4,360	0	1.00
2.00	PAIN CLINIC	76.04	13,080	0	2.00
3.00	CT SCAN	57.00	8,720	0	3.00
4.00	MRI	58.00	8,720	0	4.00
	0		34,880	0	
K - RECLASS DRCTOR OF EVS AND FOOD SRVC					
1.00	HOUSEKEEPING	9.00	24,767	0	1.00
2.00	OPERATION OF PLANT	7.00	49,536	0	2.00
3.00	NONPATIENT TELEPHONES	5.01	18,576	0	3.00

RECLASSIFICATIONS

Provider CCN: 14-0052

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

Worksheet A-6

Date/Time Prepared:
2/26/2019 8:45 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
4.00	DIETARY	10.00	24,768	0	4.00	
	O		117,647	0		
M - RECLASS OF CARDIOLOGY MGR						
1.00	CARDIAC CATHETERIZATION	59.00	52,876	0	1.00	
	O		52,876	0		
N - RECLASS OF ICU MGR						
1.00	RESPIRATORY THERAPY	65.00	18,828	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	2,461	0	2.00	
	O		21,289	0		
O - RECLASS L&D NRSES SALARIES						
1.00	NURSERY	43.00	273,100	0	1.00	
	O		273,100	0		
P - TO RECLASS DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,323	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	
	O		0	15,323		
Q - TO RECLASS PEROPERATIVE SALARIES						
1.00	RECOVERY ROOM	51.00	10,157	0	1.00	
2.00	CENTRAL SERVICES & SUPPLY	14.00	10,157	0	2.00	
3.00	EMERGENCY	91.00	10,157	0	3.00	
4.00	NURSING ADMINISTRATION	13.00	976	0	4.00	
	O		31,447	0		
R - TO RECLASS RADIOLOGY MANAGER SALARIE						
1.00	PAIN CLINIC	76.04	4,085	0	1.00	
2.00	CT SCAN	57.00	8,171	0	2.00	
3.00	MRI	58.00	8,171	0	3.00	
4.00	ELECTROENCEPHALOGRAPHY	70.00	4,085	0	4.00	
	O		24,512	0		
S - TO RECLASS MAINTENANCE COST						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	478,415	1.00	
2.00	LABORATORY	60.00	0	71,603	2.00	
	TOTALS		0	550,018		
500.00	Grand Total: Increases		628,064	8,132,360	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0052

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

Worksheet A-6
Date/Time Prepared:
2/26/2019 8:45 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - RECLASS SHORT TERM DISABILITY						
1.00	OPERATION OF PLANT	7.00	1,738	0	0	1.00
2.00	HOUSEKEEPING	9.00	656	0	0	2.00
3.00	NURSING ADMINISTRATION	13.00	1,558	0	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	498	0	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	14,393	0	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	9,530	0	0	6.00
7.00	SUBPROVIDER - IRF	41.00	9	0	0	7.00
8.00	OPERATING ROOM	50.00	3,117	0	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	2,958	0	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	2,785	0	0	10.00
11.00	LABORATORY	60.00	184	0	0	11.00
12.00	INTRAVENOUS THERAPY	64.00	681	0	0	12.00
13.00	EMERGENCY	91.00	1,878	0	0	13.00
14.00	SAINT CLARE'S VILLA	193.07	1,954	0	0	14.00
0			41,939	0		
B - TO RECLASS PROPERTY INSURANCE						
1.00		0.00	0	0	12	1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	129,908	0	2.00
0			0	129,908		
C - TO RECLASS REHAB ADMINISTRATION						
1.00	PHYSICAL THERAPY	66.00	53,204	1,606	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		53,204	1,606		
D - TO RECLASS INTEREST EXPENSE						
1.00	OTHER CAP REL COSTS	3.00	0	7,309	11	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	7,309		
E - MINISTRY COST ALLOCATION						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	1,683,987	0	1.00
2.00		0.00	0	0	0	2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	601,751	0	3.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
	TOTALS		0	2,285,738		
F - RECLASS CANCER NAVIGATOR						
1.00	INTRAVENOUS THERAPY	64.00	19,109	0	0	1.00
0			19,109	0		
G - RECLASS MEDICAL BILLABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	26,765	0	1.00
2.00	OPERATING ROOM	50.00	0	1,572,578	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	315,424	0	3.00
4.00	RESPIRATORY THERAPY	65.00	0	109,615	0	4.00
0			0	2,024,382		
H - TO RECLASS IMPLANTABLE DEVICES						
1.00	INTENSIVE CARE UNIT	31.00	0	405	0	1.00
2.00	OPERATING ROOM	50.00	0	1,208,850	0	2.00
3.00	CARDIAC CATHETERIZATION	59.00	0	541,907	0	3.00
4.00	EMERGENCY	91.00	0	17	0	4.00
0			0	1,751,179		
I - RECLASS DEPRECIATION EXPENSE						
1.00		0.00	0	0	9	1.00
2.00		0.00	0	0	9	2.00
3.00		0.00	0	0	9	3.00
4.00		0.00	0	0	9	4.00
5.00		0.00	0	0	9	5.00
6.00		0.00	0	0	9	6.00
7.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,127,279	9	7.00
8.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	197,679	9	8.00
0			0	1,324,958		
J - RECLASS OF IMAGING MGR AND SPRVSR						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	34,880	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
0			34,880	0		

RECLASSIFICATIONS

Provider CCN: 14-0052

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

Worksheet A-6

Date/Time Prepared:
2/26/2019 8:45 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
K - RECLASS DRCTOR OF EVS AND FOOD SRVC							
1.00	CAFETERIA	11.00	117,647	0	0	0	1.00
2.00		0.00	0	0	0	0	2.00
3.00		0.00	0	0	0	0	3.00
4.00		0.00	0	0	0	0	4.00
			117,647	0			
M - RECLASS OF CARDIOLOGY MGR							
1.00	ELECTROCARDIOLOGY	69.00	52,876	0	0	0	1.00
			52,876	0			
N - RECLASS OF ICU MGR							
1.00	INTENSIVE CARE UNIT	31.00	21,289	0	0	0	1.00
2.00		0.00	0	0	0	0	2.00
			21,289	0			
O - RECLASS L&D NRSES SALARIES							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	273,100	0	0	0	1.00
			273,100	0			
P - TO RECLASS DRUGS CHARGED TO PATIENTS							
1.00	ADULTS & PEDIATRICS	30.00	0	299	0	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	246	0	0	2.00
3.00	OPERATING ROOM	50.00	0	80	0	0	3.00
4.00	CT SCAN	57.00	0	14,698	0	0	4.00
			0	15,323			
Q - TO RECLASS PEROPERATIVE SALARIES							
1.00	OPERATING ROOM	50.00	31,447	0	0	0	1.00
2.00		0.00	0	0	0	0	2.00
3.00		0.00	0	0	0	0	3.00
4.00		0.00	0	0	0	0	4.00
			31,447	0			
R - TO RECLASS RADIOLOGY MANAGER SALARIE							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	24,512	0	0	0	1.00
2.00		0.00	0	0	0	0	2.00
3.00		0.00	0	0	0	0	3.00
4.00		0.00	0	0	0	0	4.00
			24,512	0			
S - TO RECLASS MAINTENANCE COST							
1.00	OPERATION OF PLANT	7.00	0	550,018	0	0	1.00
2.00		0.00	0	0	0	0	2.00
	TOTALS		0	550,018			
500.00	Grand Total: Decreases		670,003	8,090,421			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

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

Worksheet A-7
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,470,000	0	0	0	0	1.00
2.00	Land Improvements	9,818,924	191,983	0	191,983	0	2.00
3.00	Buildings and Fixtures	58,810,767	2,170,425	0	2,170,425	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	35,517,335	2,691,952	0	2,691,952	5,339,890	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	105,617,026	5,054,360	0	5,054,360	5,339,890	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	105,617,026	5,054,360	0	5,054,360	5,339,890	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,470,000	0				1.00
2.00	Land Improvements	10,010,907	0				2.00
3.00	Buildings and Fixtures	60,981,192	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	32,869,397	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	105,331,496	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	105,331,496	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

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

Worksheet A-7
Part II
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,840,469	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	1,461,391	0	0	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.02
3.00	Total (sum of lines 1-2)	4,301,860	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	2,840,469	1.00			
1.01	CAP REL COSTS-BLDG & FIXT	0	0	1.01			
1.02	CAP REL COSTS-BLDG & FIXT	0	0	1.02			
1.03	CAP REL COSTS-BLDG & FIXT	0	0	1.03			
1.04	CAP REL COSTS-BLDG & FIXT	0	0	1.04			
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,461,391	2.00			
2.01	CAP REL COSTS-MVBLE EQUIP	0	0	2.01			
2.02	CAP REL COSTS-MVBLE EQUIP	0	0	2.02			
3.00	Total (sum of lines 1-2)	0	4,301,860	3.00			

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0052

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

Worksheet A-7
Part III
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL			
	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
	1.00	2.00	3.00	4.00	5.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	51,562,970	0	51,562,970	0.496459	64,495	1.00
1.01	CAP REL COSTS-BLDG & FIXT	8,942,591	0	8,942,591	0.086101	11,185	1.01
1.02	CAP REL COSTS-BLDG & FIXT	1,717,364	0	1,717,364	0.016535	2,148	1.02
1.03	CAP REL COSTS-BLDG & FIXT	6,694,629	0	6,694,629	0.064457	8,373	1.03
1.04	CAP REL COSTS-BLDG & FIXT	2,074,543	0	2,074,543	0.019974	2,595	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	25,088,437	0	25,088,437	0.241557	31,380	2.00
2.01	CAP REL COSTS-MVBLE EQUIP	7,663,296	0	7,663,296	0.073784	9,585	2.01
2.02	CAP REL COSTS-MVBLE EQUIP	117,666	0	117,666	0.001133	147	2.02
3.00	Total (sum of lines 1-2)	103,861,496	0	103,861,496	1.000000	129,908	3.00
ALLOCATION OF OTHER CAPITAL							
Cost Center Description	Taxes	Other Capital-Related Costs	Total (sum of col. 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	-3,629	60,866	1,988,529	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	-629	10,556	809,640	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT	0	-121	2,027	54,413	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT	0	-471	7,902	216,632	0	1.03
1.04	CAP REL COSTS-BLDG & FIXT	0	-146	2,449	46,594	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	-1,766	29,614	1,424,840	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP	0	-539	9,046	196,238	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP	0	-8	139	1,441	0	2.02
3.00	Total (sum of lines 1-2)	0	-7,309	122,599	4,738,327	0	3.00
SUMMARY OF CAPITAL							
Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 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	444,809	64,495	0	-3,629	2,494,204	1.00
1.01	CAP REL COSTS-BLDG & FIXT	0	11,185	0	-629	820,196	1.01
1.02	CAP REL COSTS-BLDG & FIXT	0	2,148	0	-121	56,440	1.02
1.03	CAP REL COSTS-BLDG & FIXT	0	8,373	0	-471	224,534	1.03
1.04	CAP REL COSTS-BLDG & FIXT	0	2,595	0	-146	49,043	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	228,849	31,380	0	-1,766	1,683,303	2.00
2.01	CAP REL COSTS-MVBLE EQUIP	0	9,585	0	-539	205,284	2.01
2.02	CAP REL COSTS-MVBLE EQUIP	0	147	0	-8	1,580	2.02
3.00	Total (sum of lines 1-2)	673,658	129,908	0	-7,309	5,534,584	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0052

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

Worksheet A-8

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.00	0 1.00
1.01 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.01	0 1.01
1.02 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.02	0 1.02
1.03 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.03	0 1.03
1.04 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT	1.04	0 1.04
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.00	0 2.00
2.01 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.01	0 2.01
2.02 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP	2.02	0 2.02
3.00 Investment income - other (chapter 2)	B	-400,804	OTHER ADMINISTRATIVE AND GENERAL	5.05	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)	B	-25,074	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 7.00
8.00 Television and radio service (chapter 21)		0		0.00	0 8.00
9.00 Parking lot (chapter 21)		0		0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-3,173,484			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	-399,645			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests	A	-373,282	CAFETERIA	11.00	0 14.00
15.00 Rental of quarters to employee and others		0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00 Sale of drugs to other than patients		0		0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-148	MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0 19.00
20.00 Vending machines		0		0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)	B	-231,988	OTHER ADMINISTRATIVE AND GENERAL	5.05	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		RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.00	0 26.00
26.01 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT	1.01	0 26.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0052

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

Worksheet A-8

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
26.02 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.02	0 26.02
26.03 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.03	0 26.03
26.04 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.04	0 26.04
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
27.01 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.01	0 27.01
27.02 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.02	0 27.02
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	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 DIETARY REVENUES	B	-9,143	0	DIETARY	10.00	0 33.00
33.01 OTHER REVENUES - INFUSION SERVICES	B	-140	0	INTRAVENOUS THERAPY	64.00	0 33.01
33.02 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0 33.02
33.03 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0 33.03
33.04 OTHER OPERATING REVENUES - ADMIN AND	B	-8,136	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 33.04
33.05 OTHER OPERATING REVENUES - MGMT FEE	B	-121,957	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 33.05
33.06 ADVERTISING - CARDIOLOGY	A	-404	0	ELECTROCARDIOLOGY	69.00	0 33.06
33.07 OTHER OPERATING REVENUES - DIETARY	B	-16,273	0	DIETARY	10.00	0 33.07
33.08 OTHER OPERATING REVENUES - PAIN MGMT	B	-3,086	0	RADIOLOGY-DIAGNOSTIC	54.00	0 33.08
33.09 OTHER OPERATING REVENUES - NURSERY	B	-64	0	NURSERY	43.00	0 33.09
33.10 ADVERTISING - INFUSION	A	-10	0	INTRAVENOUS THERAPY	64.00	0 33.10
33.11 OTHER OPERATING REVENUES - NURSING A	B	-1,230	0	NURSING ADMINISTRATION	13.00	0 33.11
33.12 OTHER OPERATING REVENUES - MED PSYCH	B	-21,038	0	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03	0 33.12
33.13 ADVERTISING - SURGERY	A	-3	0	OPERATING ROOM	50.00	0 33.13
33.14 MEDICAID PROVIDER TAX	A	-4,931,425	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 33.14
33.15 ADVERTISING - ADMIN	A	-12,389	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 33.15
33.16 ADVERTISING - EMPLOYEE BENEFITS	A	-830	0	ADULTS & PEDIATRICS	30.00	0 33.16
33.17 ADVERTISING - ICU	A	-116	0	INTENSIVE CARE UNIT	31.00	0 33.17
33.18 ADVERTISING - OPERATING ROOM	A	-24	0	EMERGENCY	91.00	0 33.18
33.19 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0 33.19
33.21 UNEMPLOYMENT COMP	A		0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.21
33.22 LOBBYING DUES	A	-34,246	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 33.22
33.25 340B OFFSET	B	-144,905	0	DRUGS CHARGED TO PATIENTS	73.00	0 33.25
33.26 PHYSICAL THERAPY	B	-585	0	PHYSICAL THERAPY	66.00	0 33.26
33.27 ADMIN AND GEN - RECRUITING	A	-2,795	0	OTHER ADMINISTRATIVE AND GENERAL	5.05	0 33.27
33.28 RECOVERY - RECRUITING	A	-500	0	RECOVERY ROOM	51.00	0 33.28
33.29 DELIVERY ROOM - RECRUITING	A	-900	0	DELIVERY ROOM & LABOR ROOM	52.00	0 33.29
33.30 LAB - RECRUITING	A	-476	0	LABORATORY	60.00	0 33.30
33.31 ER - RECRUITING	A		0	EMERGENCY	91.00	0 33.31
33.32 PHYSICIAN EMPLOYEE BENEFITS	A	-941	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.32

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0052

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

Worksheet A-8

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
33.33 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.33
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,916,041				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: 14-0052

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

Worksheet A-8-1

Date/Time Prepared: 2/26/2019 8:45 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITAL	275,339	0
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	1,206,558	1,045,430
3.00	5.05	OTHER ADMINISTRATIVE AND GEN	A&G HO MANAGEMENT	4,185,444	9,331,972
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	MINISTRY ALLOCATION	1,301,051	1,301,051
3.02	0.00			0	0
3.03	0.00			0	0
3.04	7.00	OPERATION OF PLANT	MINISTRY ALLOCATION	197,069	197,069
3.05	17.00	SOCIAL SERVICE	HO FUNCTIONAL - CARE MANAGEM	452,484	601,751
3.06	31.00	INTENSIVE CARE UNIT	MINISTRY ALLOCATION	133,061	133,061
3.07	66.00	PHYSICAL THERAPY	MINISTRY ALLOCATION	51,505	51,505
3.08	67.00	OCCUPATIONAL THERAPY	MINISTRY ALLOCATION	20,860	20,860
3.09	68.00	SPEECH PATHOLOGY	MINISTRY ALLOCATION	10,281	10,281
3.10	73.00	DRUGS CHARGED TO PATIENTS	MINISTRY ALLOCATION	480,892	480,892
4.00	1.00	CAP REL COSTS-BLDG & FIXT	HO INTEREST (OPERATING)	444,809	0
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	HO INTEREST (OPERATING)	228,849	0
4.02	13.00	NURSING ADMINISTRATION	HO FUNCTIONAL - NURSING ADM	373,679	0
4.03	5.05	OTHER ADMINISTRATIVE AND GEN	HO FUNCTIONAL - ADMIN & GENE	3,419,503	0
4.04	30.00	ADULTS & PEDIATRICS	SFI RENT - A&P	8,257	14,192
4.05	57.00	CT SCAN	SFI RENT - A&P	1,701	2,923
4.06	60.00	LABORATORY	SYSTEMS LAB	701,714	701,714
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			13,493,056	13,892,701

* 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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

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

Provider CCN: 14-0052

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

Worksheet A-8-1

Date/Time Prepared:
2/26/2019 8:45 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	275,339	9		1.00
2.00	161,128	9		2.00
3.00	-5,146,528	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	-149,267	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
4.00	444,809	11		4.00
4.01	228,849	11		4.01
4.02	373,679	0		4.02
4.03	3,419,503	0		4.03
4.04	-5,935	0		4.04
4.05	-1,222	0		4.05
4.06	0	0		4.06
5.00	-399,645			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	CATHOLIC SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0052

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

Worksheet A-8-2

Date/Time Prepared:
2/26/2019 8:45 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	5,538	0	5,538	211,500	36	1.00
2.00	13.00	NURSING ADMINISTRATION	133,648	133,648	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	243,840	243,840	0	0	0	3.00
4.00	43.00	NURSERY	355,066	355,066	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	814,000	814,000	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	100,000	100,000	0	0	0	6.00
7.00	60.00	LABORATORY	92,033	45,833	46,200	260,300	389	7.00
8.00	69.00	ELECTROCARDIOLOGY	73,885	73,885	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	44,116	44,116	0	0	0	9.00
10.00	91.00	EMERGENCY	274,521	274,521	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	1,086,698	1,086,698	0	0	0	11.00
200.00			3,223,345	3,171,607	51,738		425	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	3,661	183	0	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	48,681	2,434	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	11.00
200.00			52,342	2,617	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.05	OTHER ADMINISTRATIVE AND GENERAL	0	3,661	1,877	1,877	1.00
2.00	13.00	NURSING ADMINISTRATION	0	0	0	133,648	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	0	0	243,840	3.00
4.00	43.00	NURSERY	0	0	0	355,066	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	814,000	5.00
6.00	59.00	CARDIAC CATHETERIZATION	0	0	0	100,000	6.00
7.00	60.00	LABORATORY	0	48,681	0	45,833	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	73,885	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	44,116	9.00
10.00	91.00	EMERGENCY	0	0	0	274,521	10.00
11.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,086,698	11.00
200.00			0	52,342	1,877	3,173,484	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BLDG & FIXT	BLDG & FIXT	BLDG & FIXT	
		0	1.00	1.01	1.02	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,494,204	2,494,204			1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT	820,196	0	820,196		1.01
1.02 00102	CAP REL COSTS-BLDG & FIXT	56,440	0	0	56,440	1.02
1.03 00103	CAP REL COSTS-BLDG & FIXT	224,534	0	0	0	1.03
1.04 00104	CAP REL COSTS-BLDG & FIXT	49,043	0	0	0	1.04
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,683,303				2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP	205,284				2.01
2.02 00202	CAP REL COSTS-MVBLE EQUIP	1,580				2.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,966,860	14,299	4,292	0	4.00
5.01 00540	NONPATIENT TELEPHONES	620,307	5,900	1,118	0	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	193,502	52,649	2,562	0	5.02
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	75,200	10,750	0	0	5.04
5.05 00590	OTHER ADMINISTRATIVE AND GENERAL	12,339,385	304,702	281,750	56,440	5.05
7.00 00700	OPERATION OF PLANT	3,770,311	213,808	58,322	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	295,707	16,083	6,196	0	8.00
9.00 00900	HOUSEKEEPING	1,086,410	68,942	23,556	0	9.00
10.00 01000	DIETARY	435,554	87,934	9,743	0	10.00
11.00 01100	CAFETERIA	587,722	42,833	13,510	0	11.00
13.00 01300	NURSING ADMINISTRATION	1,268,318	13,805	5,503	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	432,781	60,344	30,294	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	809,719	29,679	2,143	0	16.00
17.00 01700	SOCIAL SERVICE	452,484	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,642,074	484,434	0	0	30.00
31.00 03100	INTENSIVE CARE UNIT	1,534,318	159,553	0	0	31.00
41.00 04100	SUBPROVIDER - IRF	6,822	0	0	0	41.00
43.00 04300	NURSERY	337,343	12,913	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,136,077	257,659	0	0	50.00
51.00 05100	RECOVERY ROOM	372,794	10,414	6,231	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	931,371	135,386	0	0	52.00
53.00 05300	ANESTHESIOLOGY	55,625	1,050	1,165	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,925,999	106,285	82,343	0	54.00
57.00 05700	CT SCAN	431,110	9,826	0	0	57.00
58.00 05800	MRI	163,982	8,451	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	374,866	23,359	0	0	59.00
60.00 06000	LABORATORY	3,812,676	105,035	25,681	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	210,810	682	2,329	0	62.00
64.00 06400	INTRAVENOUS THERAPY	461,253	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	616,209	22,876	5,451	0	65.00
66.00 06600	PHYSICAL THERAPY	897,912	9,921	25,996	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	403,675	2,278	42,534	0	67.00
68.00 06800	SPEECH PATHOLOGY	227,536	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	261,295	31,799	4,688	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	287,491	5,974	2,900	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,958,401	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,751,179	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	7,750,384	24,807	7,116	0	73.00
76.00 03950	THERAPEUTIC ACTIVITIES	0	0	0	0	76.00
76.03 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	468,552	0	0	0	76.03
76.04 03952	PAIN CLINIC	105,123	5,323	0	0	76.04
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	2,318,220	138,630	33,234	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	72,311,941	2,478,383	678,657	56,440	4,220
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	885	9,574	0	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	273,223	0	0	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00
193.02 19302	FUND DEVELOPMENT	254,609	0	0	0	193.02
193.05 19305	EMS	98,048	1,638	0	0	193.05
193.07 19307	SAINT CLARE'S VILLA	3,418	0	0	0	193.07
194.00 07950	UNUSED SPACE	0	4,609	141,539	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation col. 7)	CAPITAL RELATED COSTS				
		BLDG & FIXT	BLDG & FIXT	BLDG & FIXT	BLDG & FIXT	
	0	1.00	1.01	1.02	1.03	
202.00 TOTAL (sum lines 118 through 201)	72,942,124	2,494,204	820,196	56,440	224,534	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		CAPITAL RELATED COSTS				EMPLOYEE BENEFITS DEPARTMENT	4.00
		BLDG & FIXT	MVBLE EQUIP	MVBLE EQUIP	MVBLE EQUIP		
		1.04	2.00	2.01	2.02		
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT					1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT	49,043				1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,683,303			2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP		0	205,284		2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP		0	0	1,580	2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,093	9,624	2,156	0	8,998,324
5.01	00540	NONPATIENT TELEPHONES	0	3,971	222	0	200,829
5.02	00560	PURCHASING RECEIVING AND STORES	0	35,438	509	0	60,192
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,486	7,236	1,773	0	4,950
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	10,239	205,096	68,158	1,580	728,347
7.00	00700	OPERATION OF PLANT	6,751	145,646	19,634	0	417,269
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,826	1,230	0	10,620
9.00	00900	HOUSEKEEPING	0	48,447	4,677	0	281,722
10.00	01000	DIETARY	155	59,188	1,934	0	85,330
11.00	01100	CAFETERIA	0	28,831	2,868	0	208,740
13.00	01300	NURSING ADMINISTRATION	0	9,964	1,093	0	290,166
14.00	01400	CENTRAL SERVICES & SUPPLY	0	40,618	6,015	0	117,230
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,977	426	0	216,387
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	326,074	0	0	1,081,694
31.00	03100	INTENSIVE CARE UNIT	0	107,396	0	0	412,412
41.00	04100	SUBPROVIDER - IIRF	0	0	0	0	2,171
43.00	04300	NURSERY	0	8,692	0	0	94,276
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	173,432	0	0	878,121
51.00	05100	RECOVERY ROOM	0	7,010	1,237	0	115,625
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	91,129	0	0	240,488
53.00	05300	ANESTHESIOLOGY	0	707	231	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,541	16,350	0	627,940
57.00	05700	CT SCAN	0	6,614	0	0	62,524
58.00	05800	MRI	0	5,688	0	0	45,499
59.00	05900	CARDIAC CATHETERIZATION	0	15,723	0	0	130,154
60.00	06000	LABORATORY	0	70,700	5,099	0	563,698
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	459	463	0	0
64.00	06400	INTRAVENOUS THERAPY	5,339	0	6,370	0	132,664
65.00	06500	RESPIRATORY THERAPY	0	15,398	1,082	0	205,443
66.00	06600	PHYSICAL THERAPY	4,177	6,678	10,145	0	283,867
67.00	06700	OCCUPATIONAL THERAPY	0	1,533	8,446	0	130,388
68.00	06800	SPEECH PATHOLOGY	1,055	0	1,258	0	74,279
69.00	06900	ELECTROCARDIOLOGY	0	21,404	931	0	84,667
70.00	07000	ELECTROENCEPHALOGRAPHY	3,112	4,021	4,289	0	25,589
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	16,698	1,413	0	303,557
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,156	0	2,572	0	165,807
76.04	03952	PAIN CLINIC	0	3,583	0	0	32,073
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	93,312	6,599	0	664,921
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,563	1,672,654	177,180	1,580	8,979,639
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,445	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,480	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0
193.05	19305	EMS	0	1,102	0	0	18,685
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	0
194.00	07950	UNUSED SPACE	0	3,102	28,104	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	49,043	1,683,303	205,284	1,580	8,998,324

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		Subtotal	NONPATIENT TELEPHONES	Subtotal	PURCHASING RECEIVING AND STORES	Subtotal	
		4A	5.01	5A.01	5.02	5A.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT					1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP					2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP					2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES	832,347	832,347			5.01
5.02	00560	PURCHASING RECEIVING AND STORES	344,852	3,981	348,833	348,833	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	101,395	1,170	102,565	493	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	13,995,697	161,540	14,157,237	68,046	14,225,283
7.00	00700	OPERATION OF PLANT	4,633,385	53,483	4,686,868	22,520	4,709,388
8.00	00800	LAUNDRY & LINEN SERVICE	340,662	3,932	344,594	1,656	346,250
9.00	00900	HOUSEKEEPING	1,515,693	17,496	1,533,189	7,367	1,540,556
10.00	01000	DIETARY	679,838	7,847	687,685	3,304	690,989
11.00	01100	CAFETERIA	884,504	10,210	894,714	4,299	899,013
13.00	01300	NURSING ADMINISTRATION	1,589,486	18,347	1,607,833	7,726	1,615,559
14.00	01400	CENTRAL SERVICES & SUPPLY	687,282	7,933	695,215	3,341	698,556
16.00	01600	MEDICAL RECORDS & LIBRARY	1,078,331	12,447	1,090,778	5,241	1,096,019
17.00	01700	SOCIAL SERVICE	452,484	5,223	457,707	2,199	459,906
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,534,276	63,882	5,598,158	26,899	5,625,057
31.00	03100	INTENSIVE CARE UNIT	2,213,679	25,552	2,239,231	10,760	2,249,991
41.00	04100	SUBPROVIDER - IRF	8,993	104	9,097	44	9,141
43.00	04300	NURSERY	453,224	5,232	458,456	2,203	460,659
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,445,289	51,312	4,496,601	21,606	4,518,207
51.00	05100	RECOVERY ROOM	513,311	5,925	519,236	2,495	521,731
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,398,374	16,141	1,414,515	6,797	1,421,312
53.00	05300	ANESTHESIOLOGY	58,778	678	59,456	286	59,742
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,830,458	44,215	3,874,673	18,618	3,893,291
57.00	05700	CT SCAN	510,074	5,888	515,962	2,479	518,441
58.00	05800	MRI	223,620	2,581	226,201	1,087	227,288
59.00	05900	CARDIAC CATHETERIZATION	544,102	6,281	550,383	2,645	553,028
60.00	06000	LABORATORY	4,582,889	52,900	4,635,789	22,275	4,658,064
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	214,743	2,479	217,222	1,044	218,266
64.00	06400	INTRAVENOUS THERAPY	605,626	6,991	612,617	2,944	615,561
65.00	06500	RESPIRATORY THERAPY	866,459	10,002	876,461	4,211	880,672
66.00	06600	PHYSICAL THERAPY	1,238,696	14,298	1,252,994	6,021	1,259,015
67.00	06700	OCCUPATIONAL THERAPY	588,854	6,797	595,651	2,862	598,513
68.00	06800	SPEECH PATHOLOGY	304,128	3,511	307,639	1,478	309,117
69.00	06900	ELECTROCARDIOLOGY	404,784	4,672	409,456	1,967	411,423
70.00	07000	ELECTROENCEPHALOGRAPHY	333,376	3,848	337,224	1,620	338,844
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,958,401	22,606	1,981,007	9,519	1,990,526
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,751,179	20,214	1,771,393	8,512	1,779,905
73.00	07300	DRUGS CHARGED TO PATIENTS	8,103,975	93,544	8,197,519	39,389	8,236,908
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	639,087	7,377	646,464	3,106	649,570
76.04	03952	PAIN CLINIC	146,102	1,686	147,788	710	148,498
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	3,254,916	37,571	3,292,487	15,820	3,308,307
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,863,349	819,896	71,850,898	343,589	71,845,654
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,904	195	17,099	82	17,181
192.00	19200	PHYSICIANS' PRIVATE OFFICES	507,017	5,852	512,869	2,464	515,333
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FUND DEVELOPMENT	254,609	2,939	257,548	1,238	258,786
193.05	19305	EMS	119,473	1,379	120,852	581	121,433
193.07	19307	SAINT CLARE'S VILLA	3,418	39	3,457	17	3,474
194.00	07950	UNUSED SPACE	177,354	2,047	179,401	862	180,263
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	72,942,124	832,347	72,942,124	348,833	72,942,124

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description			CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	103,058					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	20,119	14,245,402	14,245,402			5.05
7.00	00700	OPERATION OF PLANT	6,664	4,716,052	1,144,562	5,860,614		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	490	346,740	84,152	46,822	477,714	8.00
9.00	00900	HOUSEKEEPING	2,180	1,542,736	374,414	196,613	0	9.00
10.00	01000	DIETARY	978	691,967	167,937	181,246	0	10.00
11.00	01100	CAFETERIA	1,272	900,285	218,495	118,318	0	11.00
13.00	01300	NURSING ADMINISTRATION	2,286	1,617,845	392,643	42,475	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	988	699,544	169,776	197,496	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,551	1,097,570	266,375	57,626	0	16.00
17.00	01700	SOCIAL SERVICE	651	460,557	111,775	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,959	5,633,016	1,367,105	832,263	155,864	30.00
31.00	03100	INTENSIVE CARE UNIT	3,184	2,253,175	546,834	274,114	31,785	31.00
41.00	04100	SUBPROVIDER - IRF	13	9,154	2,222	0	0	41.00
43.00	04300	NURSERY	652	461,311	111,958	22,185	3,992	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,393	4,524,600	1,098,098	442,663	74,309	50.00
51.00	05100	RECOVERY ROOM	738	522,469	126,801	37,191	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,011	1,423,323	345,433	232,595	11,520	52.00
53.00	05300	ANESTHESIOLOGY	85	59,827	14,520	5,411	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,509	3,898,800	946,219	437,631	49,098	54.00
57.00	05700	CT SCAN	734	519,175	126,001	16,882	0	57.00
58.00	05800	MRI	322	227,610	55,240	14,519	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	783	553,811	134,407	40,131	26,165	59.00
60.00	06000	LABORATORY	6,591	4,664,655	1,132,088	259,992	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	309	218,575	53,047	8,387	0	62.00
64.00	06400	INTRAVENOUS THERAPY	871	616,432	149,605	99,361	5,536	64.00
65.00	06500	RESPIRATORY THERAPY	1,246	881,918	214,037	56,183	0	65.00
66.00	06600	PHYSICAL THERAPY	1,782	1,260,797	305,989	175,294	18,514	66.00
67.00	06700	OCCUPATIONAL THERAPY	847	599,360	145,462	135,650	0	67.00
68.00	06800	SPEECH PATHOLOGY	437	309,554	75,127	19,623	0	68.00
69.00	06900	ELECTROCARDIOLOGY	582	412,005	99,992	69,151	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	479	339,323	82,352	77,159	972	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,817	1,993,343	483,774	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,519	1,782,424	432,585	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,655	8,248,563	2,001,885	64,660	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	919	650,489	157,870	40,113	0	76.03
76.04	03952	PAIN CLINIC	210	148,708	36,091	9,144	0	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	4,681	3,312,988	804,046	341,101	99,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,507	71,844,103	13,978,917	4,551,999	477,590	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	24	17,205	4,176	16,449	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	729	516,062	125,246	843,064	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	366	259,152	62,895	0	0	193.02
193.05	19305	EMS	172	121,605	29,513	2,814	124	193.05
193.07	19307	SAINT CLARE'S VILLA	5	3,479	844	0	0	193.07
194.00	07950	UNUSED SPACE	255	180,518	43,811	446,288	0	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 through 201)	103,058	72,942,124	14,245,402	5,860,614	477,714	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
2.00	00200						2.00
2.01	00201						2.01
2.02	00202						2.02
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
5.04	00580						5.04
5.05	00590						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	2,113,763					9.00
10.00	01000	68,203	1,109,353				10.00
11.00	01100	44,523	0	1,281,621			11.00
13.00	01300	15,984	0	39,708	2,108,655		13.00
14.00	01400	74,319	0	40,910	0	1,182,045	14.00
16.00	01600	21,685	0	49,673	0	2	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	313,183	873,941	220,099	753,039	32,139	30.00
31.00	03100	103,150	121,455	73,172	199,592	13,172	31.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	8,348	13,338	16,209	0	2,211	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	166,575	7,407	137,930	430,902	0	50.00
51.00	05100	13,995	0	16,907	62,889	7,688	51.00
52.00	05200	87,526	38,508	33,852	174,756	4,240	52.00
53.00	05300	2,036	0	0	0	10,790	53.00
54.00	05400	164,682	0	115,284	13,358	62,819	54.00
57.00	05700	6,353	0	11,478	0	23,005	57.00
58.00	05800	5,464	0	7,639	0	6,553	58.00
59.00	05900	15,101	0	21,327	39,699	0	59.00
60.00	06000	97,836	0	126,491	0	15,665	60.00
62.00	06200	3,156	0	0	0	43,640	62.00
64.00	06400	37,390	0	27,454	42,387	8,082	64.00
65.00	06500	21,142	0	40,949	0	0	65.00
66.00	06600	65,964	0	52,931	0	1,403	66.00
67.00	06700	51,046	0	8,880	0	244	67.00
68.00	06800	7,384	0	14,774	0	49	68.00
69.00	06900	26,022	0	12,137	17,146	572	69.00
70.00	07000	29,035	0	4,614	0	722	70.00
71.00	07100	0	0	0	0	492,123	71.00
72.00	07200	0	0	0	0	405,442	72.00
73.00	07300	24,332	0	41,065	0	1,475	73.00
76.00	03950	0	0	0	0	0	76.00
76.03	03550	15,094	0	28,773	0	0	76.03
76.04	03952	3,441	0	7,019	6,661	2,155	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	128,357	32,361	128,430	251,954	47,115	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,621,326	1,087,010	1,277,705	1,992,383	1,181,306	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	6,190	22,343	0	0	15	190.00
192.00	19200	317,248	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.02	19302	0	0	0	0	0	193.02
193.05	19305	1,059	0	3,916	0	706	193.05
193.07	19307	0	0	0	116,272	18	193.07
194.00	07950	167,940	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		2,113,763	1,109,353	1,281,621	2,108,655	1,182,045	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0052

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

Worksheet B
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,492,931					16.00
17.00	01700	SOCIAL SERVICE	0	572,332				17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,509	469,918	10,692,076	0	10,692,076	30.00
31.00	03100	INTENSIVE CARE UNIT	13,543	81,972	3,711,964	0	3,711,964	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	11,376	0	11,376	41.00
43.00	04300	NURSERY	1,915	20,442	661,909	0	661,909	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	187,355	0	7,069,839	0	7,069,839	50.00
51.00	05100	RECOVERY ROOM	25,371	0	813,311	0	813,311	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,460	0	2,361,213	0	2,361,213	52.00
53.00	05300	ANESTHESIOLOGY	19,241	0	111,825	0	111,825	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	128,712	0	5,816,603	0	5,816,603	54.00
57.00	05700	CT SCAN	160,512	0	863,406	0	863,406	57.00
58.00	05800	MRI	26,013	0	343,038	0	343,038	58.00
59.00	05900	CARDIAC CATHETERIZATION	32,126	0	862,767	0	862,767	59.00
60.00	06000	LABORATORY	173,519	0	6,470,246	0	6,470,246	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,996	0	331,801	0	331,801	62.00
64.00	06400	INTRAVENOUS THERAPY	13,112	0	999,359	0	999,359	64.00
65.00	06500	RESPIRATORY THERAPY	24,240	0	1,238,469	0	1,238,469	65.00
66.00	06600	PHYSICAL THERAPY	36,736	0	1,917,628	0	1,917,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,034	0	950,676	0	950,676	67.00
68.00	06800	SPEECH PATHOLOGY	2,570	0	429,081	0	429,081	68.00
69.00	06900	ELECTROCARDIOLOGY	56,354	0	693,379	0	693,379	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	24,385	0	558,562	0	558,562	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,710	0	3,036,950	0	3,036,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,640	0	2,660,091	0	2,660,091	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	248,148	0	10,630,128	0	10,630,128	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,750	0	897,089	0	897,089	76.03
76.04	03952	PAIN CLINIC	5,211	0	218,430	0	218,430	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	135,769	0	5,281,956	0	5,281,956	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,492,931	572,332	69,633,172	0	69,633,172	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	66,378	0	66,378	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,801,620	0	1,801,620	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	322,047	0	322,047	193.02
193.05	19305	EMS	0	0	159,737	0	159,737	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	120,613	0	120,613	193.07
194.00	07950	UNUSED SPACE	0	0	838,557	0	838,557	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,492,931	572,332	72,942,124	0	72,942,124	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0052

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

Worksheet B
Part II
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
			BLDG & FIXT	BLDG & FIXT	BLDG & FIXT	BLDG & FIXT	
			0	1.00	1.01	1.02	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT					1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP					2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP					2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	14,299	4,292	0	0 4.00
5.01	00540	NONPATIENT TELEPHONES	0	5,900	1,118	0	0 5.01
5.02	00560	PURCHASING RECEIVING AND STORES	76,900	52,649	2,562	0	0 5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	10,750	0	0	0 5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	156,659	304,702	281,750	56,440	0 5.05
7.00	00700	OPERATION OF PLANT	1,085	213,808	58,322	0	1,644 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,083	6,196	0	0 8.00
9.00	00900	HOUSEKEEPING	0	68,942	23,556	0	1,939 9.00
10.00	01000	DIETARY	0	87,934	9,743	0	0 10.00
11.00	01100	CAFETERIA	0	42,833	13,510	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	0	13,805	5,503	0	637 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,087	60,344	30,294	0	0 14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,679	2,143	0	0 16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,517	484,434	0	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	13,526	159,553	0	0	0 31.00
41.00	04100	SUBPROVIDER - IRF	131	0	0	0	0 41.00
43.00	04300	NURSERY	0	12,913	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	15,946	257,659	0	0	0 50.00
51.00	05100	RECOVERY ROOM	0	10,414	6,231	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	135,386	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,050	1,165	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	106,285	82,343	0	0 54.00
57.00	05700	CT SCAN	0	9,826	0	0	0 57.00
58.00	05800	MRI	0	8,451	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	23,359	0	0	0 59.00
60.00	06000	LABORATORY	37,264	105,035	25,681	0	0 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	682	2,329	0	0 62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	3,717	22,876	5,451	0	0 65.00
66.00	06600	PHYSICAL THERAPY	2,084	9,921	25,996	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,278	42,534	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,799	4,688	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,974	2,900	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	24,807	7,116	0	0 73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0 76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	288	0	0	0	0 76.03
76.04	03952	PAIN CLINIC	0	5,323	0	0	0 76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	138,630	33,234	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	352,204	2,478,383	678,657	56,440	4,220 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,574	0	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,244	0	0	0	220,314 192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0 193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0 193.02
193.05	19305	EMS	0	1,638	0	0	0 193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	0 193.07
194.00	07950	UNUSED SPACE	0	4,609	141,539	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	511,448	2,494,204	820,196	56,440	224,534 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/26/2019 8: 45 pm
-------------------------------------	--	-----------------------	---	---

Cost Center Description		CAPITAL RELATED COSTS				Subtotal 2A	
		BLDG & FIXT	MVBLE EQUIP	MVBLE EQUIP	MVBLE EQUIP		
		1. 04	2. 00	2. 01	2. 02		
GENERAL SERVICE COST CENTERS							
1. 00	00100	CAP REL COSTS-BLDG & FIXT					1. 00
1. 01	00101	CAP REL COSTS-BLDG & FIXT					1. 01
1. 02	00102	CAP REL COSTS-BLDG & FIXT					1. 02
1. 03	00103	CAP REL COSTS-BLDG & FIXT					1. 03
1. 04	00104	CAP REL COSTS-BLDG & FIXT					1. 04
2. 00	00200	CAP REL COSTS-MVBLE EQUIP					2. 00
2. 01	00201	CAP REL COSTS-MVBLE EQUIP					2. 01
2. 02	00202	CAP REL COSTS-MVBLE EQUIP					2. 02
4. 00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,093	9,624	2,156	0	31,464 4. 00
5. 01	00540	NONPATIENT TELEPHONES	0	3,971	222	0	11,211 5. 01
5. 02	00560	PURCHASING RECEIVING AND STORES	0	35,438	509	0	168,058 5. 02
5. 04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,486	7,236	1,773	0	21,245 5. 04
5. 05	00590	OTHER ADMINISTRATIVE AND GENERAL	10,239	205,096	68,158	1,580	1,084,624 5. 05
7. 00	00700	OPERATION OF PLANT	6,751	145,646	19,634	0	446,890 7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	0	10,826	1,230	0	34,335 8. 00
9. 00	00900	HOUSEKEEPING	0	48,447	4,677	0	147,561 9. 00
10. 00	01000	DIETARY	155	59,188	1,934	0	158,954 10. 00
11. 00	01100	CAFETERIA	0	28,831	2,868	0	88,042 11. 00
13. 00	01300	NURSING ADMINISTRATION	0	9,964	1,093	0	31,002 13. 00
14. 00	01400	CENTRAL SERVICES & SUPPLY	0	40,618	6,015	0	140,358 14. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	0	19,977	426	0	52,225 16. 00
17. 00	01700	SOCIAL SERVICE	0	0	0	0	0 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00	03000	ADULTS & PEDIATRICS	0	326,074	0	0	852,025 30. 00
31. 00	03100	INTENSIVE CARE UNIT	0	107,396	0	0	280,475 31. 00
41. 00	04100	SUBPROVIDER - IRF	0	0	0	0	131 41. 00
43. 00	04300	NURSERY	0	8,692	0	0	21,605 43. 00
44. 00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44. 00
ANCILLARY SERVICE COST CENTERS							
50. 00	05000	OPERATING ROOM	0	173,432	0	0	447,037 50. 00
51. 00	05100	RECOVERY ROOM	0	7,010	1,237	0	24,892 51. 00
52. 00	05200	DELIVERY ROOM & LABOR ROOM	0	91,129	0	0	226,515 52. 00
53. 00	05300	ANESTHESIOLOGY	0	707	231	0	3,153 53. 00
54. 00	05400	RADIOLOGY-DIAGNOSTIC	0	71,541	16,350	0	276,519 54. 00
57. 00	05700	CT SCAN	0	6,614	0	0	16,440 57. 00
58. 00	05800	MRI	0	5,688	0	0	14,139 58. 00
59. 00	05900	CARDIAC CATHETERIZATION	0	15,723	0	0	39,082 59. 00
60. 00	06000	LABORATORY	0	70,700	5,099	0	243,779 60. 00
62. 00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	459	463	0	3,933 62. 00
64. 00	06400	INTRAVENOUS THERAPY	5,339	0	6,370	0	11,709 64. 00
65. 00	06500	RESPIRATORY THERAPY	0	15,398	1,082	0	48,524 65. 00
66. 00	06600	PHYSICAL THERAPY	4,177	6,678	10,145	0	59,001 66. 00
67. 00	06700	OCCUPATIONAL THERAPY	0	1,533	8,446	0	54,791 67. 00
68. 00	06800	SPEECH PATHOLOGY	1,055	0	1,258	0	2,313 68. 00
69. 00	06900	ELECTROCARDIOLOGY	0	21,404	931	0	58,822 69. 00
70. 00	07000	ELECTROENCEPHALOGRAPHY	3,112	4,021	4,289	0	20,296 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	16,698	1,413	0	50,034 73. 00
76. 00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0 76. 00
76. 03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,156	0	2,572	0	5,016 76. 03
76. 04	03952	PAIN CLINIC	0	3,583	0	0	8,906 76. 04
OUTPATIENT SERVICE COST CENTERS							
91. 00	09100	EMERGENCY	0	93,312	6,599	0	271,775 91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92. 00
SPECIAL PURPOSE COST CENTERS							
113. 00	11300	INTEREST EXPENSE					
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	35,563	1,672,654	177,180	1,580	5,456,881 118. 00
NONREIMBURSABLE COST CENTERS							
190. 00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,445	0	0	16,019 190. 00
192. 00	19200	PHYSICIANS' PRIVATE OFFICES	13,480	0	0	0	393,038 192. 00
193. 00	19300	NONPAID WORKERS	0	0	0	0	0 193. 00
193. 02	19302	FUND DEVELOPMENT	0	0	0	0	0 193. 02
193. 05	19305	EMS	0	1,102	0	0	2,740 193. 05
193. 07	19307	SAINT CLARE'S VILLA	0	0	0	0	0 193. 07
194. 00	07950	UNUSED SPACE	0	3,102	28,104	0	177,354 194. 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 through 201)	49,043	1,683,303	205,284	1,580	6,046,032 202. 00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/26/2019 8:45 pm	
Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT 4.00	NONPATIENT TELEPHONES 5.01	PURCHASING RECEIVING AND STORES 5.02	CASHIERING/ACCOUNTS RECEIVABLE 5.04	OTHER ADMINISTRATIVE AND GENERAL 5.05	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101	CAP REL COSTS-BLDG & FIXT					1.01
1.02 00102	CAP REL COSTS-BLDG & FIXT					1.02
1.03 00103	CAP REL COSTS-BLDG & FIXT					1.03
1.04 00104	CAP REL COSTS-BLDG & FIXT					1.04
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201	CAP REL COSTS-MVBLE EQUIP					2.01
2.02 00202	CAP REL COSTS-MVBLE EQUIP					2.02
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	31,464				4.00
5.01 00540	NONPATIENT TELEPHONES	702	11,913			5.01
5.02 00560	PURCHASING RECEIVING AND STORES	210	57	168,325		5.02
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	17	17	238	21,517	5.04
5.05 00590	OTHER ADMINISTRATIVE AND GENERAL	2,547	2,325	32,811	4,226	1,126,533
7.00 00700	OPERATION OF PLANT	1,459	765	10,869	1,389	90,510
8.00 00800	LAUNDRY & LINEN SERVICE	37	56	799	102	6,655
9.00 00900	HOUSEKEEPING	985	250	3,555	454	29,608
10.00 01000	DIETARY	298	112	1,595	204	13,280
11.00 01100	CAFETERIA	730	146	2,075	265	17,278
13.00 01300	NURSING ADMINISTRATION	1,015	262	3,729	477	31,050
14.00 01400	CENTRAL SERVICES & SUPPLY	410	113	1,612	206	13,426
16.00 01600	MEDICAL RECORDS & LIBRARY	757	178	2,530	323	21,065
17.00 01700	SOCIAL SERVICE	0	75	1,061	136	8,839
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	3,783	913	12,982	1,659	108,109
31.00 03100	INTENSIVE CARE UNIT	1,442	365	5,193	664	43,243
41.00 04100	SUBPROVIDER - IRF	8	1	21	3	176
43.00 04300	NURSERY	330	75	1,063	136	8,853
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,070	733	10,428	1,333	86,836
51.00 05100	RECOVERY ROOM	404	85	1,204	154	10,027
52.00 05200	DELIVERY ROOM & LABOR ROOM	841	231	3,280	419	27,316
53.00 05300	ANESTHESIOLOGY	0	10	138	18	1,148
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,196	632	8,985	1,149	74,826
57.00 05700	CT SCAN	219	84	1,197	153	9,964
58.00 05800	MRI	159	37	525	67	4,368
59.00 05900	CARDIAC CATHETERIZATION	455	90	1,276	163	10,629
60.00 06000	LABORATORY	1,971	756	10,750	1,374	89,524
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	35	504	64	4,195
64.00 06400	INTRAVENOUS THERAPY	464	100	1,421	182	11,831
65.00 06500	RESPIRATORY THERAPY	718	143	2,033	260	16,926
66.00 06600	PHYSICAL THERAPY	993	204	2,906	371	24,197
67.00 06700	OCCUPATIONAL THERAPY	456	97	1,381	177	11,503
68.00 06800	SPEECH PATHOLOGY	260	50	713	91	5,941
69.00 06900	ELECTROCARDIOLOGY	296	67	950	121	7,907
70.00 07000	ELECTROENCEPHALOGRAPHY	89	55	782	100	6,512
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	323	4,594	587	38,256
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	289	4,108	525	34,208
73.00 07300	DRUGS CHARGED TO PATIENTS	1,061	1,337	19,010	2,430	158,332
76.00 03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0
76.03 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	580	105	1,499	192	12,484
76.04 03952	PAIN CLINIC	112	24	343	44	2,854
OUTPATIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	2,325	537	7,635	976	63,583
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	31,399	11,734	165,795	21,194	1,105,459
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3	40	5	330
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	84	1,189	152	9,904
193.00 19300	NONPAID WORKERS	0	0	0	0	0
193.02 19302	FUND DEVELOPMENT	0	42	597	76	4,974
193.05 19305	EMS	65	20	280	36	2,334
193.07 19307	SAINT CLARE'S VILLA	0	1	8	1	67
194.00 07950	UNUSED SPACE	0	29	416	53	3,465
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	31,464	11,913	168,325	21,517	1,126,533

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/26/2019 8:45 pm	
Cost Center Description			OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	551,882					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,409	46,393				8.00
9.00	00900	HOUSEKEEPING	18,515	0	200,928			9.00
10.00	01000	DIETARY	17,068	0	6,483	197,994		10.00
11.00	01100	CAFETERIA	11,142	0	4,232	0	123,910	11.00
13.00	01300	NURSING ADMINISTRATION	4,000	0	1,519	0	3,839	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,598	0	7,065	0	3,955	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,426	0	2,061	0	4,803	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	78,372	15,137	29,770	155,977	21,280	30.00
31.00	03100	INTENSIVE CARE UNIT	25,813	3,087	9,805	21,677	7,074	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	2,089	388	794	2,381	1,567	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	41,685	7,216	15,834	1,322	13,335	50.00
51.00	05100	RECOVERY ROOM	3,502	0	1,330	0	1,635	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	21,903	1,119	8,320	6,873	3,273	52.00
53.00	05300	ANESTHESIOLOGY	510	0	194	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,211	4,768	15,654	0	11,146	54.00
57.00	05700	CT SCAN	1,590	0	604	0	1,110	57.00
58.00	05800	MRI	1,367	0	519	0	739	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,779	2,541	1,435	0	2,062	59.00
60.00	06000	LABORATORY	24,483	0	9,300	0	12,229	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	790	0	300	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	9,357	538	3,554	0	2,654	64.00
65.00	06500	RESPIRATORY THERAPY	5,291	0	2,010	0	3,959	65.00
66.00	06600	PHYSICAL THERAPY	16,507	1,798	6,270	0	5,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,774	0	4,852	0	859	67.00
68.00	06800	SPEECH PATHOLOGY	1,848	0	702	0	1,428	68.00
69.00	06900	ELECTROCARDIOLOGY	6,512	0	2,474	0	1,173	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,266	94	2,760	0	446	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	6,089	0	2,313	0	3,970	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,777	0	1,435	0	2,782	76.03
76.04	03952	PAIN CLINIC	861	0	327	0	679	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	32,121	9,695	12,201	5,776	12,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	428,655	46,381	154,117	194,006	123,531	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,549	0	588	3,988	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,387	0	30,158	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0	193.02
193.05	19305	EMS	265	12	101	0	379	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	0	193.07
194.00	07950	UNUSED SPACE	42,026	0	15,964	0	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 through 201)	551,882	46,393	200,928	197,994	123,910	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/26/2019 8:45 pm	
Cost Center Description			NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			13.00	14.00	16.00	17.00	24.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT						1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT						1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT						1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	76,893					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	185,743				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	89,368			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	10,111		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	27,459	5,050	2,486	8,302	1,323,304	30.00
31.00	03100	INTENSIVE CARE UNIT	7,278	2,070	811	1,448	410,445	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	340	41.00
43.00	04300	NURSERY	0	347	115	361	40,104	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,713	0	11,219	0	655,761	50.00
51.00	05100	RECOVERY ROOM	2,293	1,208	1,519	0	48,253	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,373	666	566	0	307,695	52.00
53.00	05300	ANESTHESIOLOGY	0	1,696	1,152	0	8,019	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	487	9,871	7,708	0	455,152	54.00
57.00	05700	CT SCAN	0	3,615	9,612	0	44,588	57.00
58.00	05800	MRI	0	1,030	1,558	0	24,508	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,448	0	1,924	0	64,884	59.00
60.00	06000	LABORATORY	0	2,462	10,391	0	407,019	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	6,857	299	0	16,977	62.00
64.00	06400	INTRAVENOUS THERAPY	1,546	1,270	785	0	45,411	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,452	0	81,316	65.00
66.00	06600	PHYSICAL THERAPY	0	220	2,200	0	119,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	38	601	0	87,529	67.00
68.00	06800	SPEECH PATHOLOGY	0	8	154	0	13,508	68.00
69.00	06900	ELECTROCARDIOLOGY	625	90	3,375	0	82,412	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	114	1,460	0	39,974	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	77,330	4,055	0	125,145	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	63,710	2,374	0	105,214	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	232	14,826	0	259,634	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	284	0	28,154	76.03
76.04	03952	PAIN CLINIC	243	339	312	0	15,044	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	9,188	7,404	8,130	0	443,763	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,653	185,627	89,368	10,111	5,253,937	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	0	0	22,524	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	513,912	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	5,689	193.02
193.05	19305	EMS	0	111	0	0	6,343	193.05
193.07	19307	SAINT CLARE'S VILLA	4,240	3	0	0	4,320	193.07
194.00	07950	UNUSED SPACE	0	0	0	0	239,307	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 through 201)	76,893	185,743	89,368	10,111	6,046,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/26/2019 8:45 pm
-------------------------------------	--	-----------------------	---	--

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT		1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT		1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT		1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP		2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP		2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00560	PURCHASING RECEIVING AND STORES		5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL		5.05
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
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 - I RF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	76.03
76.04	03952	PAIN CLINIC	0	76.04
OUTPATIENT SERVICE COST CENTERS				
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.02	19302	FUND DEVELOPMENT	0	193.02
193.05	19305	EMS	0	193.05
193.07	19307	SAINT CLARE'S VILLA	0	193.07
194.00	07950	UNUSED SPACE	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT (SQUARE FEET)		
		1.00	1.01	1.02	1.03	1.04		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	237,582				1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT	0	140,844			1.01	
1.02	00102	CAP REL COSTS-BLDG & FIXT	0	0	36,641		1.02	
1.03	00103	CAP REL COSTS-BLDG & FIXT	0	0	0	33,464	1.03	
1.04	00104	CAP REL COSTS-BLDG & FIXT	0	0	0	0	50,600	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP						2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP						2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,362	737	0	0	1,128	4.00
5.01	00540	NONPATIENT TELEPHONES	562	192	0	0	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5,015	440	0	0	0	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,024	0	0	0	1,533	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	29,024	48,382	36,641	0	10,564	5.05
7.00	00700	OPERATION OF PLANT	20,366	10,015	0	245	6,965	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	1,064	0	0	0	8.00
9.00	00900	HOUSEKEEPING	6,567	4,045	0	289	0	9.00
10.00	01000	DIETARY	8,376	1,673	0	0	160	10.00
11.00	01100	CAFETERIA	4,080	2,320	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,315	945	0	95	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,748	5,202	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,827	368	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,144	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	15,198	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	1,230	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,543	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	992	1,070	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,896	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	100	200	0	100	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,124	14,140	0	0	0	54.00
57.00	05700	CT SCAN	936	0	0	0	0	57.00
58.00	05800	MRI	805	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,225	0	0	2	0	59.00
60.00	06000	LABORATORY	10,005	4,410	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65	400	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	5,509	64.00
65.00	06500	RESPIRATORY THERAPY	2,179	936	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	945	4,464	0	0	4,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	217	7,304	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,088	68.00
69.00	06900	ELECTROCARDIOLOGY	3,029	805	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	569	498	0	0	3,211	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	2,363	1,222	0	0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	2,224	76.03
76.04	03952	PAIN CLINIC	507	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	13,205	5,707	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	236,075	116,539	36,641	629	36,692	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	912	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	32,835	13,908	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0	193.02
193.05	19305	EMS	156	0	0	0	0	193.05
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	0	193.07
194.00	07950	UNUSED SPACE	439	24,305	0	0	0	194.00
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)	2,494,204	820,196	56,440	224,534	49,043	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.498287	5.823436	1.540351	6.709718	0.969229	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)					
		1.00	1.01	1.02	1.03	1.04	
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part II)						205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		2.00	2.01	2.02			
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT					1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	238,211				2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP	0	177,536			2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP	0	0	36,641		2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,362	1,865	0	26,066,517	4.00
5.01	00540	NONPATIENT TELEPHONES	562	192	0	581,765	-832,347
5.02	00560	PURCHASING RECEIVING AND STORES	5,015	440	0	174,366	0
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,024	1,533	0	14,338	0
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	29,024	58,946	36,641	2,109,892	0
7.00	00700	OPERATION OF PLANT	20,611	16,980	0	1,208,755	0
8.00	00800	LAUNDRY & LINEN SERVICE	1,532	1,064	0	30,765	0
9.00	00900	HOUSEKEEPING	6,856	4,045	0	816,099	0
10.00	01000	DIETARY	8,376	1,673	0	247,186	0
11.00	01100	CAFETERIA	4,080	2,480	0	604,682	0
13.00	01300	NURSING ADMINISTRATION	1,410	945	0	840,558	0
14.00	01400	CENTRAL SERVICES & SUPPLY	5,748	5,202	0	339,595	0
16.00	01600	MEDICAL RECORDS & LIBRARY	2,827	368	0	626,834	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	46,144	0	0	3,133,454	0
31.00	03100	INTENSIVE CARE UNIT	15,198	0	0	1,194,684	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	6,289	0
43.00	04300	NURSERY	1,230	0	0	273,100	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,543	0	0	2,543,760	0
51.00	05100	RECOVERY ROOM	992	1,070	0	334,944	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,896	0	0	696,652	0
53.00	05300	ANESTHESIOLOGY	100	200	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,124	14,140	0	1,819,030	0
57.00	05700	CT SCAN	936	0	0	181,122	0
58.00	05800	MRI	805	0	0	131,803	0
59.00	05900	CARDIAC CATHETERIZATION	2,225	0	0	377,033	0
60.00	06000	LABORATORY	10,005	4,410	0	1,632,933	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	65	400	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	5,509	0	384,304	0
65.00	06500	RESPIRATORY THERAPY	2,179	936	0	595,133	0
66.00	06600	PHYSICAL THERAPY	945	8,774	0	822,311	0
67.00	06700	OCCUPATIONAL THERAPY	217	7,304	0	377,711	0
68.00	06800	SPEECH PATHOLOGY	0	1,088	0	215,172	0
69.00	06900	ELECTROCARDIOLOGY	3,029	805	0	245,265	0
70.00	07000	ELECTROENCEPHALOGRAPHY	569	3,709	0	74,126	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	2,363	1,222	0	879,349	0
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,224	0	480,314	0
76.04	03952	PAIN CLINIC	507	0	0	92,910	0
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	13,205	5,707	0	1,926,156	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	236,704	153,231	36,641	26,012,390	-832,347
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	912	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FUND DEVELOPMENT	0	0	0	0	0
193.05	19305	EMS	156	0	0	54,127	0
193.07	19307	SAINT CLARE'S VILLA	0	0	0	0	0
194.00	07950	UNUSED SPACE	439	24,305	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
	2.00	2.01	2.02			
202.00	Cost to be allocated (per Wkst. B, Part I)	1,683,303	205,284	1,580	8,998,324	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7.066437	1.156295	0.043121	0.345206	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)				31,464	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)				0.001207	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		NONPATIENT TELEPHONES (ACCUM. COST)	Reconciliation	PURCHASING RECEIVING AND STORES (ACCUM. COST)	Reconciliation	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)		
		5.01	5A.02	5.02	5A.04	5.04		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01	
1.02	00102	CAP REL COSTS-BLDG & FIXT					1.02	
1.03	00103	CAP REL COSTS-BLDG & FIXT					1.03	
1.04	00104	CAP REL COSTS-BLDG & FIXT					1.04	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
2.01	00201	CAP REL COSTS-MVBLE EQUIP					2.01	
2.02	00202	CAP REL COSTS-MVBLE EQUIP					2.02	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00540	NONPATIENT TELEPHONES	72,109,777				5.01	
5.02	00560	PURCHASING RECEIVING AND STORES	344,852	-348,833	72,593,291		5.02	
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	101,395	0	102,565	-103,058	72,839,066	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	13,995,697	0	14,157,237	0	14,225,283	5.05
7.00	00700	OPERATION OF PLANT	4,633,385	0	4,686,868	0	4,709,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	340,662	0	344,594	0	346,250	8.00
9.00	00900	HOUSEKEEPING	1,515,693	0	1,533,189	0	1,540,556	9.00
10.00	01000	DIETARY	679,838	0	687,685	0	690,989	10.00
11.00	01100	CAFETERIA	884,504	0	894,714	0	899,013	11.00
13.00	01300	NURSING ADMINISTRATION	1,589,486	0	1,607,833	0	1,615,559	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	687,282	0	695,215	0	698,556	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,078,331	0	1,090,778	0	1,096,019	16.00
17.00	01700	SOCIAL SERVICE	452,484	0	457,707	0	459,906	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,534,276	0	5,598,158	0	5,625,057	30.00
31.00	03100	INTENSIVE CARE UNIT	2,213,679	0	2,239,231	0	2,249,991	31.00
41.00	04100	SUBPROVIDER - IRF	8,993	0	9,097	0	9,141	41.00
43.00	04300	NURSERY	453,224	0	458,456	0	460,659	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,445,289	0	4,496,601	0	4,518,207	50.00
51.00	05100	RECOVERY ROOM	513,311	0	519,236	0	521,731	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,398,374	0	1,414,515	0	1,421,312	52.00
53.00	05300	ANESTHESIOLOGY	58,778	0	59,456	0	59,742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,830,458	0	3,874,673	0	3,893,291	54.00
57.00	05700	CT SCAN	510,074	0	515,962	0	518,441	57.00
58.00	05800	MRI	223,620	0	226,201	0	227,288	58.00
59.00	05900	CARDIAC CATHETERIZATION	544,102	0	550,383	0	553,028	59.00
60.00	06000	LABORATORY	4,582,889	0	4,635,789	0	4,658,064	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	214,743	0	217,222	0	218,266	62.00
64.00	06400	INTRAVENOUS THERAPY	605,626	0	612,617	0	615,561	64.00
65.00	06500	RESPIRATORY THERAPY	866,459	0	876,461	0	880,672	65.00
66.00	06600	PHYSICAL THERAPY	1,238,696	0	1,252,994	0	1,259,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	588,854	0	595,651	0	598,513	67.00
68.00	06800	SPEECH PATHOLOGY	304,128	0	307,639	0	309,117	68.00
69.00	06900	ELECTROCARDIOLOGY	404,784	0	409,456	0	411,423	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	333,376	0	337,224	0	338,844	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,958,401	0	1,981,007	0	1,990,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,751,179	0	1,771,393	0	1,779,905	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,103,975	0	8,197,519	0	8,236,908	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	639,087	0	646,464	0	649,570	76.03
76.04	03952	PAIN CLINIC	146,102	0	147,788	0	148,498	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	3,254,916	0	3,292,487	0	3,308,307	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	71,031,002	-348,833	71,502,065	-103,058	71,742,596	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,904	0	17,099	0	17,181	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	507,017	0	512,869	0	515,333	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.02	19302	FUND DEVELOPMENT	254,609	0	257,548	0	258,786	193.02
193.05	19305	EMS	119,473	0	120,852	0	121,433	193.05
193.07	19307	SAINT CLARE'S VILLA	3,418	0	3,457	0	3,474	193.07
194.00	07950	UNUSED SPACE	177,354	0	179,401	0	180,263	194.00
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)	832,347		348,833		103,058	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011543		0.004805		0.001415	203.00

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet B-1 Date/Time Prepared: 2/26/2019 8:45 pm	
Cost Center Description		NONPATIENT TELEPHONES (ACCUM. COST)	Reconciliation	PURCHASING RECEIVING AND STORES (ACCUM. COST)	Reconciliation	CASHIERING/ACC OUNTS RECEIVABLE (ACCUM. COST)	
		5.01	5A.02	5.02	5A.04	5.04	
204.00	Cost to be allocated (per Wkst. B, Part II)	11,913		168,325		21,517	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000165		0.002319		0.000295	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.05	5.05	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT					1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT					1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT					1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP					2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP					2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-14,245,402	58,696,722			5.05
7.00	00700	OPERATION OF PLANT	0	4,716,052	324,936		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	346,740	2,596	392,181	8.00
9.00	00900	HOUSEKEEPING	0	1,542,736	10,901	0	311,439
10.00	01000	DIETARY	0	691,967	10,049	0	10,049
11.00	01100	CAFETERIA	0	900,285	6,560	0	6,560
13.00	01300	NURSING ADMINISTRATION	0	1,617,845	2,355	0	2,355
14.00	01400	CENTRAL SERVICES & SUPPLY	0	699,544	10,950	0	10,950
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,097,570	3,195	0	3,195
17.00	01700	SOCIAL SERVICE	0	460,557	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	5,633,016	46,144	127,958	46,144
31.00	03100	INTENSIVE CARE UNIT	0	2,253,175	15,198	26,094	15,198
41.00	04100	SUBPROVIDER - IIRF	0	9,154	0	0	0
43.00	04300	NURSERY	0	461,311	1,230	3,277	1,230
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	4,524,600	24,543	61,004	24,543
51.00	05100	RECOVERY ROOM	0	522,469	2,062	0	2,062
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,423,323	12,896	9,457	12,896
53.00	05300	ANESTHESIOLOGY	0	59,827	300	0	300
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,898,800	24,264	40,307	24,264
57.00	05700	CT SCAN	0	519,175	936	0	936
58.00	05800	MRI	0	227,610	805	0	805
59.00	05900	CARDIAC CATHETERIZATION	0	553,811	2,225	21,480	2,225
60.00	06000	LABORATORY	0	4,664,655	14,415	0	14,415
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	218,575	465	0	465
64.00	06400	INTRAVENOUS THERAPY	0	616,432	5,509	4,545	5,509
65.00	06500	RESPIRATORY THERAPY	0	881,918	3,115	0	3,115
66.00	06600	PHYSICAL THERAPY	0	1,260,797	9,719	15,199	9,719
67.00	06700	OCCUPATIONAL THERAPY	0	599,360	7,521	0	7,521
68.00	06800	SPEECH PATHOLOGY	0	309,554	1,088	0	1,088
69.00	06900	ELECTROCARDIOLOGY	0	412,005	3,834	0	3,834
70.00	07000	ELECTROENCEPHALOGRAPHY	0	339,323	4,278	798	4,278
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,993,343	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,782,424	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,248,563	3,585	0	3,585
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	650,489	2,224	0	2,224
76.04	03952	PAIN CLINIC	0	148,708	507	0	507
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	EMERGENCY	0	3,312,988	18,912	81,960	18,912
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-14,245,402	57,598,701	252,381	392,079	238,884
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17,205	912	0	912
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	516,062	46,743	0	46,743
193.00	19300	NONPAID WORKERS	0	0	0	0	0
193.02	19302	FUND DEVELOPMENT	0	259,152	0	0	0
193.05	19305	EMS	0	121,605	156	102	156
193.07	19307	SAINT CLARE'S VILLA	0	3,479	0	0	0
194.00	07950	UNUSED SPACE	0	180,518	24,744	0	24,744
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		14,245,402	5,860,614	477,714	2,113,763
203.00		Unit cost multiplier (Wkst. B, Part I)		0.242695	18.036210	1.218096	6.787085

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	
		5A.05	5.05	7.00	8.00	9.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		1,126,533	551,882	46,393	200,928	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		0.019192	1.698433	0.118295	0.645160	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		DIETARY (PATIENT MEALS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (PURCHASE R EQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
1.01	00101						1.01
1.02	00102						1.02
1.03	00103						1.03
1.04	00104						1.04
2.00	00200						2.00
2.01	00201						2.01
2.02	00202						2.02
4.00	00400						4.00
5.01	00540						5.01
5.02	00560						5.02
5.04	00580						5.04
5.05	00590						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	36,097					10.00
11.00	01100	0	33,051				11.00
13.00	01300	0	1,024	297,241			13.00
14.00	01400	0	1,055	0	5,105,474		14.00
16.00	01600	0	1,281	0	8	383,639,540	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28,437	5,676	106,150	138,816	10,667,826	30.00
31.00	03100	3,952	1,887	28,135	56,893	3,480,681	31.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	434	418	0	9,551	492,058	43.00
44.00	04400	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	241	3,557	60,741	0	48,150,891	50.00
51.00	05100	0	436	8,865	33,204	6,520,556	51.00
52.00	05200	1,253	873	24,634	18,313	2,431,197	52.00
53.00	05300	0	0	0	46,604	4,945,100	53.00
54.00	05400	0	2,973	1,883	271,327	33,079,515	54.00
57.00	05700	0	296	0	99,361	41,252,056	57.00
58.00	05800	0	197	0	28,303	6,685,517	58.00
59.00	05900	0	550	5,596	0	8,256,502	59.00
60.00	06000	0	3,262	0	67,660	44,594,995	60.00
62.00	06200	0	0	0	188,491	1,284,018	62.00
64.00	06400	0	708	5,975	34,909	3,369,752	64.00
65.00	06500	0	1,056	0	0	6,229,651	65.00
66.00	06600	0	1,365	0	6,059	9,441,399	66.00
67.00	06700	0	229	0	1,054	2,578,878	67.00
68.00	06800	0	381	0	213	660,450	68.00
69.00	06900	0	313	2,417	2,472	14,483,124	69.00
70.00	07000	0	119	0	3,120	6,267,006	70.00
71.00	07100	0	0	0	2,125,564	17,401,635	71.00
72.00	07200	0	0	0	1,751,179	10,187,709	72.00
73.00	07300	0	1,059	0	6,372	63,725,795	73.00
76.00	03950	0	0	0	0	0	76.00
76.03	03550	0	742	0	1	1,220,742	76.03
76.04	03952	0	181	939	9,308	1,339,368	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100	1,053	3,312	35,516	203,500	34,893,119	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		35,370	32,950	280,851	5,102,282	383,639,540	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	727	0	0	65	0	190.00
192.00	19200	0	0	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.02	19302	0	0	0	0	0	193.02
193.05	19305	0	101	0	3,049	0	193.05
193.07	19307	0	0	16,390	78	0	193.07
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		1,109,353	1,281,621	2,108,655	1,182,045	1,492,931	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1

Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		DIETARY (PATIENT MEALS)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (PURCHASE R EQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		10.00	11.00	13.00	14.00	16.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	30.732554	38.777072	7.094092	0.231525	0.003891	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	197,994	123,910	76,893	185,743	89,368	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.485054	3.749054	0.258689	0.036381	0.000233	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		17.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	CAP REL COSTS-BLDG & FIXT	1.01
1.02	00102	CAP REL COSTS-BLDG & FIXT	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT	1.03
1.04	00104	CAP REL COSTS-BLDG & FIXT	1.04
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
2.01	00201	CAP REL COSTS-MVBLE EQUIP	2.01
2.02	00202	CAP REL COSTS-MVBLE EQUIP	2.02
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	5.02
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	5.05
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
		11,255	
INPATIENT ROUTINE SERVICE COST CENTERS			
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
44.00	04400	SKILLED NURSING FACILITY	44.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
64.00	06400	INTRAVENOUS THERAPY	64.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.03
76.04	03952	PAIN CLINIC	76.04
OUTPATIENT SERVICE COST CENTERS			
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		11,255	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
193.00	19300	NONPAID WORKERS	193.00
193.02	19302	FUND DEVELOPMENT	193.02
193.05	19305	EMS	193.05
193.07	19307	SAINT CLARE'S VILLA	193.07
194.00	07950	UNUSED SPACE	194.00
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)	202.00
		572,332	
203.00		Unit cost multiplier (Wkst. B, Part I)	203.00
		50.851355	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0052

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

Worksheet B-1
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		SOCIAL SERVICE (TOTAL PATIENT DAYS)	
		17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	10,111	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.898356	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/26/2019 8:45 pm
--	--	-----------------------	---	---

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII Hospital PPS			
				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	10,692,076		10,692,076	0	10,692,076	30.00
31.00	03100 INTENSIVE CARE UNIT	3,711,964		3,711,964	0	3,711,964	31.00
41.00	04100 SUBPROVIDER - I RF	11,376		11,376	0	11,376	41.00
43.00	04300 NURSERY	661,909		661,909	0	661,909	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	7,069,839		7,069,839	0	7,069,839	50.00
51.00	05100 RECOVERY ROOM	813,311		813,311	0	813,311	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,361,213		2,361,213	0	2,361,213	52.00
53.00	05300 ANESTHESIOLOGY	111,825		111,825	0	111,825	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,816,603		5,816,603	0	5,816,603	54.00
57.00	05700 CT SCAN	863,406		863,406	0	863,406	57.00
58.00	05800 MRI	343,038		343,038	0	343,038	58.00
59.00	05900 CARDIAC CATHETERIZATION	862,767		862,767	0	862,767	59.00
60.00	06000 LABORATORY	6,470,246		6,470,246	0	6,470,246	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	331,801		331,801	0	331,801	62.00
64.00	06400 INTRAVENOUS THERAPY	999,359		999,359	0	999,359	64.00
65.00	06500 RESPIRATORY THERAPY	1,238,469	0	1,238,469	0	1,238,469	65.00
66.00	06600 PHYSICAL THERAPY	1,917,628	0	1,917,628	0	1,917,628	66.00
67.00	06700 OCCUPATIONAL THERAPY	950,676	0	950,676	0	950,676	67.00
68.00	06800 SPEECH PATHOLOGY	429,081	0	429,081	0	429,081	68.00
69.00	06900 ELECTROCARDIOLOGY	693,379		693,379	0	693,379	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	558,562		558,562	0	558,562	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,036,950		3,036,950	0	3,036,950	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,660,091		2,660,091	0	2,660,091	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,630,128		10,630,128	0	10,630,128	73.00
76.00	03950 THERAPEUTIC ACTIVITIES	0		0	0	0	76.00
76.03	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	897,089		897,089	0	897,089	76.03
76.04	03952 PAIN CLINIC	218,430		218,430	0	218,430	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	5,281,956		5,281,956	0	5,281,956	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,295,454		1,295,454	0	1,295,454	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	70,928,626	0	70,928,626	0	70,928,626	200.00
201.00	Less Observation Beds	1,295,454		1,295,454	0	1,295,454	201.00
202.00	Total (see instructions)	69,633,172	0	69,633,172	0	69,633,172	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
	Inpatient	Outpatient	Total (col. 6 + col. 7)			
	6.00	7.00	8.00			
9.00	10.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,907,597		8,907,597	30.00
31.00	03100	INTENSIVE CARE UNIT	3,480,681		3,480,681	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	41.00
43.00	04300	NURSERY	492,058		492,058	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,541,915	38,608,976	48,150,891	50.00
51.00	05100	RECOVERY ROOM	1,627,199	4,893,357	6,520,556	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,962,094	469,103	2,431,197	52.00
53.00	05300	ANESTHESIOLOGY	1,275,684	3,669,416	4,945,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,874,131	28,205,384	33,079,515	54.00
57.00	05700	CT SCAN	9,277,276	31,974,780	41,252,056	57.00
58.00	05800	MRI	1,657,748	5,027,769	6,685,517	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,868,989	4,387,513	8,256,502	59.00
60.00	06000	LABORATORY	13,518,949	31,076,046	44,594,995	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	670,406	613,612	1,284,018	62.00
64.00	06400	INTRAVENOUS THERAPY	18,990	3,350,762	3,369,752	64.00
65.00	06500	RESPIRATORY THERAPY	4,139,499	2,090,152	6,229,651	65.00
66.00	06600	PHYSICAL THERAPY	1,093,063	8,348,336	9,441,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,161,114	1,417,764	2,578,878	67.00
68.00	06800	SPEECH PATHOLOGY	241,900	418,550	660,450	68.00
69.00	06900	ELECTROCARDIOLOGY	5,588,389	8,894,735	14,483,124	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	158,366	6,108,640	6,267,006	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,542,294	9,859,341	17,401,635	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,449,404	4,738,305	10,187,709	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,031,072	49,694,723	63,725,795	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	210	1,220,532	1,220,742	76.03
76.04	03952	PAIN CLINIC	30,392	1,308,976	1,339,368	76.04
OUTPATIENT SERVICE COST CENTERS						
91.00	09100	EMERGENCY	6,136,172	28,756,947	34,893,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	538,914	1,221,315	1,760,229	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)	107,284,506	276,355,034	383,639,540	200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)	107,284,506	276,355,034	383,639,540	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.146827		50.00
51.00	05100 RECOVERY ROOM	0.124730		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.971214		52.00
53.00	05300 ANESTHESIOLOGY	0.022613		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.175837		54.00
57.00	05700 CT SCAN	0.020930		57.00
58.00	05800 MRI	0.051311		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.104495		59.00
60.00	06000 LABORATORY	0.145089		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.258408		62.00
64.00	06400 INTRAVENOUS THERAPY	0.296568		64.00
65.00	06500 RESPIRATORY THERAPY	0.198802		65.00
66.00	06600 PHYSICAL THERAPY	0.203108		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.368639		67.00
68.00	06800 SPEECH PATHOLOGY	0.649680		68.00
69.00	06900 ELECTROCARDIOLOGY	0.047875		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.089127		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.174521		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.261108		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.166810		73.00
76.00	03950 THERAPEUTIC ACTIVITIES	0.000000		76.00
76.03	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.734872		76.03
76.04	03952 PAIN CLINIC	0.163084		76.04
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.151375		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.735958		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0052

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

Worksheet C
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	10,692,076		10,692,076	0	10,692,076	30.00
31.00	03100 INTENSIVE CARE UNIT	3,711,964		3,711,964	0	3,711,964	31.00
41.00	04100 SUBPROVIDER - I RF	11,376		11,376	0	11,376	41.00
43.00	04300 NURSERY	661,909		661,909	0	661,909	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	7,069,839		7,069,839	0	7,069,839	50.00
51.00	05100 RECOVERY ROOM	813,311		813,311	0	813,311	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,361,213		2,361,213	0	2,361,213	52.00
53.00	05300 ANESTHESIOLOGY	111,825		111,825	0	111,825	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	5,816,603		5,816,603	0	5,816,603	54.00
57.00	05700 CT SCAN	863,406		863,406	0	863,406	57.00
58.00	05800 MRI	343,038		343,038	0	343,038	58.00
59.00	05900 CARDIAC CATHETERIZATION	862,767		862,767	0	862,767	59.00
60.00	06000 LABORATORY	6,470,246		6,470,246	0	6,470,246	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	331,801		331,801	0	331,801	62.00
64.00	06400 INTRAVENOUS THERAPY	999,359		999,359	0	999,359	64.00
65.00	06500 RESPIRATORY THERAPY	1,238,469	0	1,238,469	0	1,238,469	65.00
66.00	06600 PHYSICAL THERAPY	1,917,628	0	1,917,628	0	1,917,628	66.00
67.00	06700 OCCUPATIONAL THERAPY	950,676	0	950,676	0	950,676	67.00
68.00	06800 SPEECH PATHOLOGY	429,081	0	429,081	0	429,081	68.00
69.00	06900 ELECTROCARDIOLOGY	693,379		693,379	0	693,379	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	558,562		558,562	0	558,562	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,036,950		3,036,950	0	3,036,950	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,660,091		2,660,091	0	2,660,091	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	10,630,128		10,630,128	0	10,630,128	73.00
76.00	03950 THERAPEUTIC ACTIVITIES	0		0	0	0	76.00
76.03	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	897,089		897,089	0	897,089	76.03
76.04	03952 PAIN CLINIC	218,430		218,430	0	218,430	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	5,281,956		5,281,956	0	5,281,956	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,295,454		1,295,454		1,295,454	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	70,928,626	0	70,928,626	0	70,928,626	200.00
201.00	Less Observation Beds	1,295,454		1,295,454		1,295,454	201.00
202.00	Total (see instructions)	69,633,172	0	69,633,172	0	69,633,172	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet C Part I Date/Time Prepared: 2/26/2019 8:45 pm	
			Title XIX		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00					
9.00	10.00							
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,907,597		8,907,597			30.00
31.00	03100	INTENSIVE CARE UNIT	3,480,681		3,480,681			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
43.00	04300	NURSERY	492,058		492,058			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,541,915	38,608,976	48,150,891	0.146827	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,627,199	4,893,357	6,520,556	0.124730	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,962,094	469,103	2,431,197	0.971214	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,275,684	3,669,416	4,945,100	0.022613	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,874,131	28,205,384	33,079,515	0.175837	0.000000	54.00
57.00	05700	CT SCAN	9,277,276	31,974,780	41,252,056	0.020930	0.000000	57.00
58.00	05800	MRI	1,657,748	5,027,769	6,685,517	0.051311	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,868,989	4,387,513	8,256,502	0.104495	0.000000	59.00
60.00	06000	LABORATORY	13,518,949	31,076,046	44,594,995	0.145089	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	670,406	613,612	1,284,018	0.258408	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	18,990	3,350,762	3,369,752	0.296568	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	4,139,499	2,090,152	6,229,651	0.198802	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,093,063	8,348,336	9,441,399	0.203108	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,161,114	1,417,764	2,578,878	0.368639	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	241,900	418,550	660,450	0.649680	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	5,588,389	8,894,735	14,483,124	0.047875	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	158,366	6,108,640	6,267,006	0.089127	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,542,294	9,859,341	17,401,635	0.174521	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,449,404	4,738,305	10,187,709	0.261108	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,031,072	49,694,723	63,725,795	0.166810	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0.000000	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	210	1,220,532	1,220,742	0.734872	0.000000	76.03
76.04	03952	PAIN CLINIC	30,392	1,308,976	1,339,368	0.163084	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	6,136,172	28,756,947	34,893,119	0.151375	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	538,914	1,221,315	1,760,229	0.735958	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	107,284,506	276,355,034	383,639,540			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	107,284,506	276,355,034	383,639,540			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/26/2019 8:45 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950 THERAPEUTIC ACTIVITIES	0.000000		76.00
76.03	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.03
76.04	03952 PAIN CLINIC	0.000000		76.04
OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part I Date/Time Prepared: 2/26/2019 8:45 pm	
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	PPS Per Diem (col. 3 / col. 4)	
Title XVIII		Hospital		PPS			
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,323,304	0	1,323,304	10,515	125.85	30.00
31.00	INTENSIVE CARE UNIT	410,445		410,445	1,612	254.62	31.00
41.00	SUBPROVIDER - IRF	340	0	340	0	0.00	41.00
43.00	NURSERY	40,104		40,104	402	99.76	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
200.00	Total (lines 30 through 199)	1,774,193		1,774,193	12,529		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	4,420	556,257				
31.00	INTENSIVE CARE UNIT	491	125,018				
41.00	SUBPROVIDER - IRF	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	4,911	681,275				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/26/2019 8:45 pm
--	-----------------------	---	--

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	655,761	48,150,891	0.013619	3,875,358	52,779	50.00
51.00	05100	RECOVERY ROOM	48,253	6,520,556	0.007400	633,713	4,689	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	307,695	2,431,197	0.126561	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,019	4,945,100	0.001622	469,494	762	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	455,152	33,079,515	0.013759	2,300,106	31,647	54.00
57.00	05700	CT SCAN	44,588	41,252,056	0.001081	4,181,560	4,520	57.00
58.00	05800	MRI	24,508	6,685,517	0.003666	746,810	2,738	58.00
59.00	05900	CARDIAC CATHETERIZATION	64,884	8,256,502	0.007859	1,200,407	9,434	59.00
60.00	06000	LABORATORY	407,019	44,594,995	0.009127	6,188,295	56,481	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,977	1,284,018	0.013222	29,660	392	62.00
64.00	06400	INTRAVENOUS THERAPY	45,411	3,369,752	0.013476	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	81,316	6,229,651	0.013053	1,768,586	23,085	65.00
66.00	06600	PHYSICAL THERAPY	119,784	9,441,399	0.012687	574,676	7,291	66.00
67.00	06700	OCCUPATIONAL THERAPY	87,529	2,578,878	0.033941	630,412	21,397	67.00
68.00	06800	SPEECH PATHOLOGY	13,508	660,450	0.020453	136,451	2,791	68.00
69.00	06900	ELECTROCARDIOLOGY	82,412	14,483,124	0.005690	2,769,113	15,756	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,974	6,267,006	0.006378	111,911	714	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,145	17,401,635	0.007192	3,100,470	22,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,214	10,187,709	0.010328	2,417,539	24,968	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	259,634	63,725,795	0.004074	5,628,173	22,929	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0.000000	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	28,154	1,220,742	0.023063	210	5	76.03
76.04	03952	PAIN CLINIC	15,044	1,339,368	0.011232	5,622	63	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	443,763	34,893,119	0.012718	3,230,586	41,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	160,332	1,760,229	0.091086	259,653	23,651	92.00
200.00		Total (lines 50 through 199)	3,640,076	370,759,204		40,258,805	369,478	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part III Date/Time Prepared: 2/26/2019 8:45 pm
---	--	-----------------------	---	---

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	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	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	10,515	0.00	4,420	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	1,612	0.00	491	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00	
43.00	04300	NURSERY	0	0	402	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)	0	0	12,529	0.00	4,911	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	-----------------------	---	--

Cost Center Description	Title XVIII			Hospital		Allied Health	Allied Health	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	PPS			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.03
76.04	03952	PAIN CLINIC	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	-----------------------	---	--

Cost Center Description	Title XVIII			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	48,150,891	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,520,556	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,431,197	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,945,100	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,079,515	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	41,252,056	0.000000	57.00
58.00	05800	MRI	0	0	0	6,685,517	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,256,502	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,594,995	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,284,018	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,369,752	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,229,651	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,441,399	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,578,878	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	660,450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,483,124	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,267,006	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,401,635	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,187,709	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	63,725,795	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,220,742	0.000000	76.03
76.04	03952	PAIN CLINIC	0	0	0	1,339,368	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	34,893,119	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,760,229	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	370,759,204		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	-----------------------	---	--

Cost Center Description		Title XVIII				Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)			
		9.00	10.00	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	3,875,358	0	10,568,432	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	633,713	0	415,839	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	469,494	0	893,004	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,300,106	0	7,997,508	0	54.00	
57.00	05700	CT SCAN	0.000000	4,181,560	0	8,152,485	0	57.00	
58.00	05800	MRI	0.000000	746,810	0	1,201,652	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,200,407	0	1,390,707	0	59.00	
60.00	06000	LABORATORY	0.000000	6,188,295	0	5,014,263	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	29,660	0	231,385	0	62.00	
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	1,091,928	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	1,768,586	0	660,460	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	574,676	0	19,058	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	630,412	0	16,629	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	136,451	0	2,205	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,769,113	0	2,762,976	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	111,911	0	1,492,340	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,100,470	0	2,547,912	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,417,539	0	1,537,755	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,628,173	0	17,790,236	0	73.00	
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00	
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	210	0	305,351	0	76.03	
76.04	03952	PAIN CLINIC	0.000000	5,622	0	290,918	0	76.04	
OUTPATIENT SERVICE COST CENTERS									
91.00	09100	EMERGENCY	0.000000	3,230,586	0	5,538,590	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	259,653	0	226,759	0	92.00	
200.00		Total (lines 50 through 199)		40,258,805	0	70,148,392	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 8:45 pm
--	--	-----------------------	---	---

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
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.146827	10,568,432	0	0	1,551,731	50.00
51.00	05100	RECOVERY ROOM	0.124730	415,839	0	0	51,868	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.971214	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022613	893,004	0	0	20,193	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175837	7,997,508	0	0	1,406,258	54.00
57.00	05700	CT SCAN	0.020930	8,152,485	0	0	170,632	57.00
58.00	05800	MRI	0.051311	1,201,652	0	0	61,658	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104495	1,390,707	0	0	145,322	59.00
60.00	06000	LABORATORY	0.145089	5,014,263	6,772	0	727,514	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.258408	231,385	0	0	59,792	62.00
64.00	06400	INTRAVENOUS THERAPY	0.296568	1,091,928	0	0	323,831	64.00
65.00	06500	RESPIRATORY THERAPY	0.198802	660,460	0	0	131,301	65.00
66.00	06600	PHYSICAL THERAPY	0.203108	19,058	0	0	3,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368639	16,629	0	0	6,130	67.00
68.00	06800	SPEECH PATHOLOGY	0.649680	2,205	0	0	1,433	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047875	2,762,976	0	0	132,277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089127	1,492,340	0	0	133,008	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.174521	2,547,912	0	0	444,664	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.261108	1,537,755	0	0	401,520	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166810	17,790,236	0	118,426	2,967,589	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.734872	305,351	0	0	224,394	76.03
76.04	03952	PAIN CLINIC	0.163084	290,918	0	0	47,444	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0.151375	5,538,590	0	0	838,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.735958	226,759	0	0	166,885	92.00
200.00		Subtotal (see instructions)		70,148,392	6,772	118,426	10,017,719	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		70,148,392	6,772	118,426	10,017,719	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/26/2019 8:45 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	983	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0		64.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	19,755		73.00
76.00 03950 THERAPEUTIC ACTIVITIES	0	0		76.00
76.03 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.03
76.04 03952 PAIN CLINIC	0	0		76.04
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	983	19,755		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	983	19,755		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0052 Component CCN: 14-T052		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part II Date/Time Prepared: 2/26/2019 8:45 pm	
			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	655,761	48,150,891	0.013619	0	0	50.00
51.00	05100	RECOVERY ROOM	48,253	6,520,556	0.007400	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	307,695	2,431,197	0.126561	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,019	4,945,100	0.001622	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	455,152	33,079,515	0.013759	0	0	54.00
57.00	05700	CT SCAN	44,588	41,252,056	0.001081	0	0	57.00
58.00	05800	MRI	24,508	6,685,517	0.003666	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	64,884	8,256,502	0.007859	0	0	59.00
60.00	06000	LABORATORY	407,019	44,594,995	0.009127	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,977	1,284,018	0.013222	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	45,411	3,369,752	0.013476	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	81,316	6,229,651	0.013053	0	0	65.00
66.00	06600	PHYSICAL THERAPY	119,784	9,441,399	0.012687	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	87,529	2,578,878	0.033941	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,508	660,450	0.020453	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	82,412	14,483,124	0.005690	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,974	6,267,006	0.006378	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,145	17,401,635	0.007192	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	105,214	10,187,709	0.010328	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	259,634	63,725,795	0.004074	0	0	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0.000000	0	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	28,154	1,220,742	0.023063	0	0	76.03
76.04	03952	PAIN CLINIC	15,044	1,339,368	0.011232	0	0	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	443,763	34,893,119	0.012718	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,760,229	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	3,479,744	370,759,204		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052 Component CCN: 14-T052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
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
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00 03950 THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.03
76.04 03952 PAIN CLINIC	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052 Component CCN: 14-T052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	---	---	--

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	48,150,891	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,520,556	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,431,197	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,945,100	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,079,515	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	41,252,056	0.000000	57.00
58.00	05800	MRI	0	0	0	6,685,517	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,256,502	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,594,995	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,284,018	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,369,752	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,229,651	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,441,399	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,578,878	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	660,450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,483,124	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,267,006	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,401,635	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,187,709	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	63,725,795	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,220,742	0.000000	76.03
76.04	03952	PAIN CLINIC	0	0	0	1,339,368	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	34,893,119	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,760,229	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	370,759,204		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052 Component CCN: 14-T052	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	---	---	--

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03950 THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00
76.03	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.03
76.04	03952 PAIN CLINIC	0.000000	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052 Component CCN: 14-5314	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	---	---	--

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950 THERAPEUTIC ACTIVITIES	0	0	0	0	0	76.00
76.03	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.03
76.04	03952 PAIN CLINIC	0	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052 Component CCN: 14-5314	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	---	---	--

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	48,150,891	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	6,520,556	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	2,431,197	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4,945,100	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	33,079,515	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	41,252,056	0.000000	57.00
58.00	05800	MRI	0	0	0	6,685,517	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,256,502	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	44,594,995	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	1,284,018	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,369,752	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,229,651	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	9,441,399	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,578,878	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	660,450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	14,483,124	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	6,267,006	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	17,401,635	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,187,709	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	63,725,795	0.000000	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0	0	0	0	0.000000	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	1,220,742	0.000000	76.03
76.04	03952	PAIN CLINIC	0	0	0	1,339,368	0.000000	76.04
OUTPATIENT SERVICE COST CENTERS								
91.00	09100	EMERGENCY	0	0	0	34,893,119	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,760,229	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	370,759,204		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0052 Component CCN: 14-5314	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/26/2019 8:45 pm
--	---	---	--

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
76.00	03950 THERAPEUTIC ACTIVITIES	0.000000	0	0	0	0	76.00
76.03	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.03
76.04	03952 PAIN CLINIC	0.000000	0	0	0	0	76.04
OUTPATIENT SERVICE COST CENTERS							
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/26/2019 8:45 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		10,515	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		10,515	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)		9,241	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,420	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)		10,692,076	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)		10,692,076	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)		10,692,076	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,016.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,494,433	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,494,433	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1	
Date/Time Prepared: 2/26/2019 8:45 pm		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
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	3,711,964	1,612	2,302.71	491	1,130,631		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)					5,944,180		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					11,569,244		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)					681,275		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					369,478		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,050,753		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					10,518,491		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)					1,274		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,016.84		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					1,295,454		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 8:45 pm	
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	1,323,304	10,692,076	0.123765	1,295,454	160,332	90.00
91.00	Nursing School cost	0	10,692,076	0.000000	1,295,454	0	91.00
92.00	Allied health cost	0	10,692,076	0.000000	1,295,454	0	92.00
93.00	All other Medical Education	0	10,692,076	0.000000	1,295,454	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1
		Component CCN: 14-T052		Date/Time Prepared: 2/26/2019 8:45 pm
		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)		0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		0	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)		0	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)		0	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)		11,376	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)		11,376	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)		11,376	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)		0.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1	
				Component CCN: 14-T052		Date/Time Prepared: 2/26/2019 8:45 pm	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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)						0	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)						0	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)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	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: 14-0052 Component CCN: 14-T052		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 8:45 pm	
		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	340	11,376	0.029887	0	0	90.00
91.00	Nursing School cost	0	11,376	0.000000	0	0	91.00
92.00	Allied health cost	0	11,376	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,376	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052 Component CCN: 14-5314	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Skilled Nursing Facility	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)			0 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			0 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)			0 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)			0 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)			0 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)			0 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)			0 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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0052 Component CCN: 14-5314		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 8:45 pm	
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)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						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)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)					0	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0.00	71.00
72.00	Program routine service cost (line 9 x line 71)					0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)					0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00	Inpatient routine service cost per diem limitation					0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)					0	83.00
84.00	Program inpatient ancillary services (see instructions)					0	84.00
85.00	Utilization review - physician compensation (see instructions)					0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					0	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: 14-0052 Component CCN: 14-5314		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/26/2019 8:45 pm	
		Title XVIII		Skilled Nursing Facility		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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/26/2019 8:45 pm	
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		4,203,129	30.00
31.00	03100	INTENSIVE CARE UNIT		1,410,915	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	0.146827	3,875,358	50.00
51.00	05100	RECOVERY ROOM	0.124730	633,713	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.971214	0	52.00
53.00	05300	ANESTHESIOLOGY	0.022613	469,494	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.175837	2,300,106	54.00
57.00	05700	CT SCAN	0.020930	4,181,560	57.00
58.00	05800	MRI	0.051311	746,810	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.104495	1,200,407	59.00
60.00	06000	LABORATORY	0.145089	6,188,295	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.258408	29,660	62.00
64.00	06400	INTRAVENOUS THERAPY	0.296568	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.198802	1,768,586	65.00
66.00	06600	PHYSICAL THERAPY	0.203108	574,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.368639	630,412	67.00
68.00	06800	SPEECH PATHOLOGY	0.649680	136,451	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047875	2,769,113	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.089127	111,911	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.174521	3,100,470	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.261108	2,417,539	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166810	5,628,173	73.00
76.00	03950	THERAPEUTIC ACTIVITIES	0.000000	0	76.00
76.03	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.734872	210	76.03
76.04	03952	PAIN CLINIC	0.163084	5,622	76.04
OUTPATIENT SERVICE COST CENTERS					
91.00	09100	EMERGENCY	0.151375	3,230,586	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.735958	259,653	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		40,258,805	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)		40,258,805	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		10,024,861	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)		55,441	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)		81.51	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.77	30.00
31.00	Percentage of Medicaid patient days (see instructions)		25.71	31.00
32.00	Sum of lines 30 and 31		30.48	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		300,746	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/26/2019 8:45 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000071137	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	481,360	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	481,360	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		481,360		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		10,862,408		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)			10,862,408	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			818,322	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)			11,680,730	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			11,680,730	61.00
62.00	Deductibles billed to program beneficiaries			1,150,300	62.00
63.00	Coinurance billed to program beneficiaries			14,644	63.00
64.00	Allowable bad debts (see instructions)			404,851	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			263,153	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			383,356	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			10,778,939	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				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)			9,371	70.93
70.94	HRR adjustment amount (see instructions)			-135,336	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		10,652,974	71.00
71.01	Sequestration adjustment (see instructions)		213,059	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		10,348,089	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		91,826	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		260,668	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1 1.00	On/After 10/1 2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)			0
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		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	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		20,738	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,017,719	2.00
3.00	OPPS payments		8,382,898	3.00
4.00	Outlier payment (see instructions)		6,914	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		20,738	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		125,198	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)		125,198	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)		125,198	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		104,460	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		20,738	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		8,389,812	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,676,766	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)		6,733,784	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)		6,733,784	30.00
31.00	Primary payer payments		2,104	31.00
32.00	Subtotal (line 30 minus line 31)		6,731,680	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)		486,863	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		316,461	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		458,982	36.00
37.00	Subtotal (see instructions)		7,048,141	37.00
38.00	MSP-LCC reconciliation amount from PS&R		402	38.00
39.00	RECONCILIATION		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		7,047,739	40.00
40.01	Sequestration adjustment (see instructions)		140,955	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		6,869,760	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		37,024	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: 14-0052

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

Worksheet E-1
Part I
Date/Time Prepared:
2/26/2019 8:45 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		10,439,013		6,890,534	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/15/2018	90,924	04/15/2018	20,774	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)		-90,924		-20,774	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)		10,348,089		6,869,760	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		91,826		37,024	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		10,439,915		6,906,784	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0052

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

Worksheet E-1
Part II
Date/Time Prepared:
2/26/2019 8:45 pm

Title XVIII		Hospital	PPS
			1.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052 Component CCN: 14-T052	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part III Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			0 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0000 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			0 3.00
4.00	Outlier Payments			0 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)			0.000000 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)			0 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)			0 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			0 19.00
20.00	Deductibles			0 20.00
21.00	Subtotal (line 19 minus line 20)			0 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			0 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			0 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	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			0 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			0 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			0 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			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0052 Component CCN: 14-5314	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

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

Provider CCN: 14-0052

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

Worksheet G
Date/Time Prepared:
2/26/2019 8:45 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,700,356	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	66,203,313	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-51,261,759	0	0	0	6.00
7.00	Inventory	2,657,925	0	0	0	7.00
8.00	Prepaid expenses	229,942	0	0	0	8.00
9.00	Other current assets	233,632	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,763,409	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,208,764	0	0	0	12.00
13.00	Land improvements	6,930,417	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	60,468,217	0	0	0	15.00
16.00	Accumulated depreciation	-48,025,037	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-6,550,269	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	32,609,180	0	0	0	23.00
24.00	Accumulated depreciation	-25,894,281	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	4,493,301	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,240,292	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,879,265	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	6,280,360	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,159,625	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	53,163,326	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	3,637,269	0	0	0	37.00
38.00	Salaries, wages, and fees payable	321,788	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	50,367,999	0	0	0	40.00
41.00	Deferred income	43,792	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	14,375	0	0	0	43.00
44.00	Other current liabilities	6,062,906	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	60,448,129	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	32,322,905	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)	32,322,905	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	92,771,034	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-39,607,708				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	-39,607,708	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	53,163,326	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0052

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

Worksheet G-1
Date/Time Prepared:
2/26/2019 8:45 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		-33,000,236			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-11,775,731				2.00
3.00	Total (sum of line 1 and line 2)		-44,775,967			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00	INCREASE IN TEMP ASSETS	372,068		0		0	6.00
7.00	PENSION ADJUSTMENT	4,400,529		0		0	7.00
8.00	ACCT 231095	636,009		0		0	8.00
9.00	ROUNDING	3		0		0	9.00
10.00	Total additions (sum of line 4-9)		5,408,609			0	10.00
11.00	Subtotal (line 3 plus line 10)		-39,367,358			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	DECREASE IN RESTRICTED ASSETS 257001	61,725		0		0	13.00
14.00	DECREASE IN TEMP REST ASSETS	33,111		0		0	14.00
15.00	OTHER DIFFERENCE	200		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)		95,036			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-39,462,394			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	INCREASE IN TEMP ASSETS		0				6.00
7.00	PENSION ADJUSTMENT		0				7.00
8.00	ACCT 231095		0				8.00
9.00	ROUNDING		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	DECREASE IN RESTRICTED ASSETS 257001		0				13.00
14.00	DECREASE IN TEMP REST ASSETS		0				14.00
15.00	OTHER DIFFERENCE		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: 14-0052

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2019 8:45 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	9,400,606		9,400,606	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	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	145,314		145,314	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)	9,545,920		9,545,920	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	3,480,681		3,480,681	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	3,480,681		3,480,681	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,026,601		13,026,601	17.00
18.00	Ancillary services	94,373,568	273,825,526	368,199,094	18.00
19.00	Outpatient services	30,602	2,529,508	2,560,110	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	13,319	925,132	938,451	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	107,444,090	277,280,166	384,724,256	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		82,858,165		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)		82,858,165		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0052

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

Worksheet G-3

Date/Time Prepared:
2/26/2019 8:45 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	384,724,256	1.00
2.00	Less contractual allowances and discounts on patients' accounts	305,393,816	2.00
3.00	Net patient revenues (line 1 minus line 2)	79,330,440	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,858,165	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,527,725	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	222,898	6.00
7.00	Income from investments	401,065	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	382,426	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	66,807	17.00
18.00	Revenue from sale of medical records and abstracts	148	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	195,942	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUES	28,885	24.00
24.01	BLUE CROSS QUALITY / RISK RESERVES	607,374	24.01
24.02	FINANCE CHARGES	231,988	24.02
25.00	Total other income (sum of lines 6-24)	2,137,533	25.00
26.00	Total (line 5 plus line 25)	-1,390,192	26.00
27.00	MINORITY INTEREST	10,503,998	27.00
27.01	STATE AND FEDERAL TAXES	3,498	27.01
27.02	ST CLAI RE VILLA	-121,957	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	10,385,539	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-11,775,731	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0052	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/26/2019 8:45 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		810,141	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		8,181	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)		29.85	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		818,322	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