

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/29/2018 10:41 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/29/2018 Time: 10:41 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY 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 HOLY CROSS HOSPITAL (14-0133) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
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	343,426	-242,859	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-6,727	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	336,699	-242,859	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/27/2018 2:18 pm
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1.00	2.00	3.00	4.00				1.00	2.00		
Hospital and Hospital Health Care Complex Address:										
Street: 2701 WEST 68TH STREET		PO Box:		Zip Code: 60629		County: COOK				
City: CHICAGO		State: IL								
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	8.00		
	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	HOLY CROSS HOSPITAL	140133	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	REHAB UNIT	14T133	16974	5	07/01/2000	N	P	P	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00
					From:		To:			
					1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)				07/01/2017		06/30/2018		20.00	
21.00	Type of Control (see instructions)				1				21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.				Y		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,228	557	54	0	15,585	935		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.	19	5	0	0	124			25.00	

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		Urban/Rural	St	Date of Geogra		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria 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
61.01	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

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
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.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
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) Teaching Hospitals that Claim Residents in Nonprovider Settings						62.01	0.00
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)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	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		0	76.00

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			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00		
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00		
			V 1.00	XIX 2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	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	N	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06		
Rural Providers						
105.00	Does this hospital qualify as a CAH?		N	105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N	108.00		
			Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
			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: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/27/2018 2:18 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			
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0			118.01
		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				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/27/2018 2:18 pm
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		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name:	Contractor's Name:		Contractor's Number:			141.00	
142.00	Street:	PO Box:					142.00	
143.00	City:	State:		Zip Code:			143.00	
							1.00	
144.00	Are provider based physicians' costs included in Worksheet A?						Y	144.00
							1.00	
							2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			Y			145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N			146.00	
							1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N			155.00
156.00	Subprovider - IPF	N	N	N	N			156.00
157.00	Subprovider - IRF	N	N	N	N			157.00
158.00	SUBPROVIDER							158.00
159.00	SNF	N	N	N	N			159.00
160.00	HOME HEALTH AGENCY	N	N	N	N			160.00
161.00	CMHC		N	N	N			161.00
161.20	OPT		N	N	N			161.20
161.30	OOT		N	N	N			161.30
161.40	OSP		N	N	N			161.40
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
		Beginni ng	Endi ng					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
							1.00	
							2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N			0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0133		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/27/2018 2:18 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)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.				Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.				N		14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.				N		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2018	Y	10/31/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/27/2018 2:18 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
				1.00	
				2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	NASIM		CORY	41.00
42.00	Enter the employer/company name of the cost report preparer	HOLY CROSS HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	773-257-6206		NASIM.CORY@SINAI.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/27/2018 2:18 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR, GOVT REIMB & REPORTING		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0133

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

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	199	72,635	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)		199	72,635	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	20	7,300	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		219	79,935	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	6	2,190		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.20 CMHC - OPT	99.20				0	25.20
25.30 CMHC - OOT	99.30				0	25.30
25.40 CMHC - OSP	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		225				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0133

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

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2018 2:18 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)	11,204	2,741	38,945			1.00
2.00 HMO and other (see instructions)	5,053	16,520				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	57	124				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)	11,204	2,741	38,945			7.00
8.00 INTENSIVE CARE UNIT	1,551	353	4,505			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		691	874			13.00
14.00 Total (see instructions)	12,755	3,785	44,324	0.00	855.50	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	365	24	584	0.00	3.50	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.20 CMHC - OPT	0	0	0	0.00	0.00	25.20
25.30 CMHC - OOT	0	0	0	0.00	0.00	25.30
25.40 CMHC - OSP	0	0	0	0.00	0.00	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	859.00	27.00
28.00 Observation Bed Days		307	4,962			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	16			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: 14-0133

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

Worksheet S-3
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,481	819	9,379	1.00
2.00	HMO and other (see instructions)			961	3,555		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				11		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,481	819	9,379	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	30	2	53	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.20	CMHC - OPT	0.00					25.20
25.30	CMHC - OOT	0.00					25.30
25.40	CMHC - OSP	0.00					25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0133		Period: From 07/01/2017 To 06/30/2018		Worksheet S-3 Part II Date/Time Prepared: 11/27/2018 2:18 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	54,273,085	4,070,548	58,343,633	1,862,863.00	31.32	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		0	0	0	0.00	0.00	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 FOHC 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)		263,019	0	263,019	7,293.00	36.06	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		1,174,050	0	1,174,050	17,106.00	68.63	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		134,646	0	134,646	1,976.00	68.14	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		0	0	0	0.00	0.00	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)		10,765,135	0	10,765,135			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		51,667	0	51,667			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		0	0	0			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/FOHC)		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)		0	0	0			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	65,342	719,257	784,599	21,338.00	36.77	26.00
27.00	Administrative & General	5.00	3,856,953	3,268,791	7,125,744	207,189.00	34.39	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0133

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

Worksheet S-3
Part II
Date/Time Prepared:
11/27/2018 2:18 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	
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,482,364	0	2,482,364	113,975.00	30.00
31.00	Laundry & Linen Service	8.00	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,066,787	0	1,066,787	76,312.00	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0.00	0.00	33.00
34.00	Dietary	10.00	926,062	-348,607	577,455	44,499.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	348,607	348,607	26,864.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,543,229	-584,537	958,692	27,651.00	38.00
39.00	Central Services and Supply	14.00	200,068	0	200,068	13,378.00	39.00
40.00	Pharmacy	15.00	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	905,787	0	905,787	28,297.00	41.00
42.00	Social Service	17.00	1,314,685	0	1,314,685	38,247.00	42.00
43.00	Other General Service	18.00	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0133

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

Worksheet S-3
Part III
Date/Time Prepared:
11/27/2018 2:18 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)	54,273,085	4,070,548	58,343,633	1,862,863.00	31.32	1.00
2.00	Excluded area salaries (see instructions)	263,019	0	263,019	7,293.00	36.06	2.00
3.00	Subtotal salaries (line 1 minus line 2)	54,010,066	4,070,548	58,080,614	1,855,570.00	31.30	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,308,696	0	1,308,696	19,082.00	68.58	4.00
5.00	Subtotal wage-related costs (see inst.)	10,765,135	0	10,765,135	0.00	18.53	5.00
6.00	Total (sum of lines 3 thru 5)	66,083,897	4,070,548	70,154,445	1,874,652.00	37.42	6.00
7.00	Total overhead cost (see instructions)	12,361,277	3,403,511	15,764,788	597,750.00	26.37	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/27/2018 2:18 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	406,885	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,063,129	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	686,991	9.00
10.00	Dental, Hearing and Vision Plan	44,405	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	63,360	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)	193,394	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,340,309	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,945,075	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	54,643	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	18,611	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,816,802	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part V Date/Time Prepared: 11/27/2018 2:18 pm
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,174,050	10,816,802	1.00
2.00	Hospital	1,174,050	10,816,802	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/27/2018 2:18 pm
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.203347	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		33,939,505	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		45,797,338	6.00
7.00	Medicaid cost (line 1 times line 6)		9,312,751	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	51,133,728	0	51,133,728
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	10,397,890	0	10,397,890
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	10,397,890	0	10,397,890
			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)		7,442,742	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		352,734	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		542,669	27.01
28.00	Non-Medicare bad debt expense (see instructions)		6,900,073	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,593,044	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		11,990,934	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		11,990,934	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0133

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

Worksheet A
Date/Time Prepared:
11/27/2018 2:18 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		3,555,468	3,555,468	275,348	3,830,816	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		4,295,488	4,295,488	977,003	5,272,491	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	65,342	12,131,053	12,196,395	6,268	12,202,663	4.00
5.01	00540	NONPATIENT TELEPHONES	274,649	780,219	1,054,868	-68,189	986,679	5.01
5.02	00550	DATA PROCESSING	90,999	3,756,069	3,847,068	-866,327	2,980,741	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	140,483	265,564	406,047	0	406,047	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	569,726	2,055,211	2,624,937	0	2,624,937	5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	2,781,096	18,355,364	21,136,460	-7,610	21,128,850	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,482,364	3,375,210	5,857,574	0	5,857,574	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	817,098	817,098	0	817,098	8.00
9.00	00900	HOUSEKEEPING	1,066,787	786,145	1,852,932	0	1,852,932	9.00
10.00	01000	DIETARY	926,062	1,220,483	2,146,545	-808,046	1,338,499	10.00
11.00	01100	CAFETERIA	0	0	0	808,046	808,046	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,543,229	174,016	1,717,245	-689,477	1,027,768	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	200,068	301,768	501,836	-12,859	488,977	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	905,787	444,936	1,350,723	0	1,350,723	16.00
17.00	01700	SOCIAL SERVICE	1,314,685	17,457	1,332,142	0	1,332,142	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,609,798	2,341,836	16,951,634	-113,386	16,838,248	30.00
31.00	03100	INTENSIVE CARE UNIT	3,584,004	1,119,651	4,703,655	-306,775	4,396,880	31.00
41.00	04100	SUBPROVIDER - IIRF	263,019	15,870	278,889	-5,702	273,187	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,952,533	2,964,045	5,916,578	-2,240,894	3,675,684	50.00
51.00	05100	RECOVERY ROOM	351,187	11,387	362,574	-5,785	356,789	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,690,908	1,718,524	3,409,432	-71,291	3,338,141	52.00
53.00	05300	ANESTHESIOLOGY	0	1,429,512	1,429,512	0	1,429,512	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,739,054	485,723	2,224,777	-170,820	2,053,957	54.00
54.02	03630	ULTRA SOUND	693,568	72,595	766,163	-20,218	745,945	54.02
56.00	05600	RADIO SOTOP	276,185	254,323	530,508	-1,681	528,827	56.00
57.00	05700	CT SCAN	601,498	283,215	884,713	-50,496	834,217	57.00
59.00	05900	CARDIAC CATHETERIZATION	291,974	376,218	668,192	-272,195	395,997	59.00
60.00	06000	LABORATORY	1,487,870	3,317,811	4,805,681	-12,349	4,793,332	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,462,531	284,347	1,746,878	-66,231	1,680,647	65.00
66.00	06600	PHYSICAL THERAPY	536,034	15,173	551,207	-1,140	550,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	418,090	7,350	425,440	0	425,440	67.00
68.00	06800	SPEECH PATHOLOGY	190,059	72,171	262,230	-173	262,057	68.00
69.00	06900	ELECTROCARDIOLOGY	537,738	56,185	593,923	-14,449	579,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	57,759	2,602	60,361	-1,292	59,069	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,606,067	3,606,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,507,442	1,507,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,255,893	3,202,784	5,458,677	-2,056	5,456,621	73.00
74.00	07400	RENAL DIALYSIS	555,684	227,480	783,164	-42,846	740,318	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,356,422	4,791,793	12,148,215	-1,011,394	11,136,821	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		316,493	316,493	-316,493	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	54,273,085	75,698,637	129,971,722	0	129,971,722	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,746	2,746	0	2,746	192.00
194.00	07950	SEASON HOSPICE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	54,273,085	75,701,383	129,974,468	0	129,974,468	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0133

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

Worksheet A
Date/Time Prepared:
11/27/2018 2:18 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	-197,072	3,633,744	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	5,272,491	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,202,663	4.00
5.01	00540	NONPATIENT TELEPHONES	0	986,679	5.01
5.02	00550	DATA PROCESSING	0	2,980,741	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	0	406,047	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,624,937	5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	-842,571	20,286,279	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-224,235	5,633,339	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	817,098	8.00
9.00	00900	HOUSEKEEPING	0	1,852,932	9.00
10.00	01000	DIETARY	-15,010	1,323,489	10.00
11.00	01100	CAFETERIA	0	808,046	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATIVE	-10,619	1,017,149	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	488,977	14.00
15.00	01500	PHARMACY	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,423	1,347,300	16.00
17.00	01700	SOCIAL SERVICE	0	1,332,142	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-532,416	16,305,832	30.00
31.00	03100	INTENSIVE CARE UNIT	0	4,396,880	31.00
41.00	04100	SUBPROVIDER - IRF	0	273,187	41.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,675,684	50.00
51.00	05100	RECOVERY ROOM	0	356,789	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,554,172	1,783,969	52.00
53.00	05300	ANESTHESIOLOGY	-1,429,512	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,100	2,051,857	54.00
54.02	03630	ULTRA SOUND	0	745,945	54.02
56.00	05600	RADIOISOTOPE	0	528,827	56.00
57.00	05700	CT SCAN	0	834,217	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	395,997	59.00
60.00	06000	LABORATORY	-400	4,792,932	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,680,647	65.00
66.00	06600	PHYSICAL THERAPY	0	550,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	425,440	67.00
68.00	06800	SPEECH PATHOLOGY	0	262,057	68.00
69.00	06900	ELECTROCARDIOLOGY	0	579,474	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	59,069	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-13,214	3,592,853	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,507,442	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-271,787	5,184,834	73.00
74.00	07400	RENAL DIALYSIS	0	740,318	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-2,735,520	8,401,301	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.20	09921	OPT	0	0	99.20
99.30	09931	OOT	0	0	99.30
99.40	09941	OSP	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-7,832,051	122,139,671	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-2,746	0	192.00
194.00	07950	SEASON HOSPICE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-7,834,797	122,139,671	200.00

RECLASSIFICATIONS

Provider CCN: 14-0133

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

Worksheet A-6
Date/Time Prepared:
11/27/2018 2:18 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA RECLASS						
1.00	CAFETERIA	11.00	348,607	0	1.00	
2.00	CAFETERIA	11.00	0	459,439	2.00	
	O		348,607	459,439		
B - BED & PT RENTAL						
1.00	ADULTS & PEDIATRICS	30.00	0	104,940	1.00	
	O		0	104,940		
C - INTEREST EXPENSE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	197,072	1.00	
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	119,421	2.00	
	O		0	316,493		
D - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	78,276	1.00	
	O		0	78,276		
E - MED SUPPLY & INPLANTABLE DEVICE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,606,067	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00		0.00	0	0	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,507,442	23.00	
26.00		0.00	0	0	26.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
	O		0	5,113,509		
F - SINAI HEALTH SYSTEM RECLASS						
1.00	DATA PROCESSING	5.02	1,511,029	0	1.00	
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05	1,588,368	0	2.00	
3.00	PURCHASING RECEIVING AND STORES	5.03	90,452	0	3.00	
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	564,724	0	4.00	
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	83,112	0	5.00	
6.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	71,421	0	6.00	
7.00	NONPATIENT TELEPHONES	5.01	78,942	0	7.00	
8.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	977,003	8.00	
9.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6,268	9.00	
	O		3,988,048	983,271		
G - DIRECTORSHIP RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	82,500	0	1.00	
	O		82,500	0		
H - NURSING ADMIN						
1.00	ADULTS & PEDIATRICS	30.00	584,537	0	1.00	
	O		584,537	0		
500.00	Grand Total: Increases		5,003,692	7,055,928	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0133

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

Worksheet A-6
Date/Time Prepared:
11/27/2018 2:18 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA RECLASS							
1.00	DIETARY	10.00	348,607	0	0		1.00
2.00	DIETARY	10.00	0	459,439	0		2.00
	0		348,607	459,439			
B - BED & PT RENTAL							
1.00	NURSING ADMINISTRATION	13.00	0	104,940	0		1.00
	0		0	104,940			
C - INTEREST EXPENSE RECLASS							
1.00	INTEREST EXPENSE	113.00	0	316,493	11		1.00
2.00		0.00	0	0	0		2.00
	0		0	316,493			
D - INSURANCE RECLASS							
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	78,276	11		1.00
	0		0	78,276			
E - MED SUPPLY & INPLANTABLE DEVICE							
1.00	ADULTS & PEDIATRICS	30.00	0	720,343	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	389,275	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	5,702	0		3.00
4.00	OPERATING ROOM	50.00	0	995,343	0		4.00
5.00	RECOVERY ROOM	51.00	0	5,785	0		5.00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	0	70,825	0		6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	97,602	0		7.00
8.00	ULTRA SOUND	54.02	0	19,268	0		8.00
9.00	RADIOISOTOPE	56.00	0	1,681	0		9.00
10.00	CT SCAN	57.00	0	49,861	0		10.00
11.00	CARDIAC CATHETERIZATION	59.00	0	88,259	0		11.00
12.00	LABORATORY	60.00	0	11,792	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	66,231	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	1,140	0		14.00
16.00	SPEECH PATHOLOGY	68.00	0	173	0		16.00
17.00	ELECTROCARDIOLOGY	69.00	0	14,449	0		17.00
18.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,292	0		18.00
19.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,056	0		19.00
20.00	CENTRAL SERVICES & SUPPLY	14.00	0	12,859	0		20.00
21.00	RENAL DIALYSIS	74.00	0	42,846	0		21.00
22.00	EMERGENCY	91.00	0	1,009,285	0		22.00
23.00	ADULTS & PEDIATRICS	30.00	0	20	0		23.00
26.00	OPERATING ROOM	50.00	0	1,245,551	0		26.00
28.00	DELIVERY ROOM & LABOR ROOM	52.00	0	466	0		28.00
29.00	RADIOLOGY-DIAGNOSTIC	54.00	0	73,218	0		29.00
30.00	ULTRA SOUND	54.02	0	950	0		30.00
32.00	CT SCAN	57.00	0	635	0		32.00
33.00	CARDIAC CATHETERIZATION	59.00	0	183,936	0		33.00
34.00	LABORATORY	60.00	0	557	0		34.00
35.00	EMERGENCY	91.00	0	2,109	0		35.00
	0		0	5,113,509			
F - SINAI HEALTH SYSTEM RECLASS							
1.00	DATA PROCESSING	5.02	0	1,511,029	0		1.00
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	1,588,368	0		2.00
3.00	PURCHASING RECEIVING AND STORES	5.03	0	90,452	0		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	719,257	0		4.00
5.00	NONPATIENT TELEPHONES	5.01	0	78,942	0		5.00
6.00	NONPATIENT TELEPHONES	5.01	0	68,189	0		6.00
7.00	DATA PROCESSING	5.02	0	866,327	0		7.00
8.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	42,487	9		8.00
9.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	6,268	0		9.00
	0		0	4,971,319			
G - DIRECTORSHIP RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	0	82,500	0		1.00
	0		0	82,500			
H - NURSING ADMIN							
1.00	NURSING ADMINISTRATION	13.00	584,537	0	0		1.00
	0		584,537	0			
500.00	Grand Total: Decreases		933,144	11,126,476			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

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

Worksheet A-7
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,700,000	0	0	0	0	1.00
2.00	Land Improvements	707,906	0	0	0	0	2.00
3.00	Buildings and Fixtures	96,330,170	5,727,197	0	5,727,197	4,800,647	3.00
4.00	Building Improvements	245,211	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	30,189,728	1,431,985	0	1,431,985	302,352	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	129,173,015	7,159,182	0	7,159,182	5,102,999	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	129,173,015	7,159,182	0	7,159,182	5,102,999	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,700,000	0				1.00
2.00	Land Improvements	707,906	0				2.00
3.00	Buildings and Fixtures	97,256,720	0				3.00
4.00	Building Improvements	245,211	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	31,319,361	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	131,229,198	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	131,229,198	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

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

Worksheet A-7
Part II
Date/Time Prepared:
11/27/2018 2:18 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	3,555,468	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,295,488	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	7,850,956	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	3,555,468				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,295,488				2.00
3.00	Total (sum of lines 1-2)	0	7,850,956				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0133

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

Worksheet A-7
Part III
Date/Time Prepared:
11/27/2018 2:18 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	99,201,931	0	99,201,931	0.755944	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	32,027,266	0	32,027,266	0.244056	0	2.00
3.00	Total (sum of lines 1-2)	131,229,197	0	131,229,197	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	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	0	0	3,555,468	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,272,491	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	8,827,959	0	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of 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	78,276	0	0	0	3,633,744	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,272,491	2.00
3.00	Total (sum of lines 1-2)	78,276	0	0	0	8,906,235	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0133

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

Worksheet A-8

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-5,729,286				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests			0		0.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 GEN HOSP - OTHER MISC A8-1	B	-12,078		OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.00
33.01 NURSING ADMIN A8-1	B	-2,136		NURSING ADMINISTRATION	13.00	0	33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
33.02 HIM A8-1	B	-3,423	MEDICAL RECORDS & LIBRARY	16.00	0	33.02
33.03 VENDING INC A8-1	B	-15,010	DIETARY	10.00	0	33.03
33.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.04
33.05 PARKING INC A8-1	B	-103,271	OPERATION OF PLANT	7.00	0	33.05
33.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.06
33.07 PHARMACY PREMIER REBATE A8-1	B	-78,660	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.08
33.09 MARKETING OFFSET A8-3	A	-88,760	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.09
33.10 LOBBYISTS OFFSET A8-4	A	-180,483	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.10
33.11 INTEREST INCOME A8-5	A	-197,072	CAP REL COSTS-BLDG & FIXT	1.00	11	33.11
33.12 INTEREST INCOME A8-5	A	-119,421	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.12
33.13 PHYSICIAN PRIV OFFICE A8-6	A	-2,746	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.13
33.14 GRANTS OFFSET A8-7	A	-25	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.14
33.15 DONATION OFFSET A8-8	A	-1,500	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.15
33.16 LOBBYING OFFSET A8-9	A	-2,061	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.16
33.17 HOSPICE OFFSET A8-10	A	-48,504	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.17
33.18 340 B REV OFFSET A8-1	B	-193,127	DRUGS CHARGED TO PATIENTS	73.00	0	33.18
33.19 MEDICAL SUPPLIES REBATES	B	-13,214	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.19
33.20 OPERATION AND PLANT A8-2	B	-120,964	OPERATION OF PLANT	7.00	0	33.20
33.21 NURSING EDUCATION A8-2	B	-8,483	NURSING ADMINISTRATION	13.00	0	33.21
33.22 OTH MISC INC A8-2	B	-19,850	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.22
33.23 OTH MISC INC A8-2	B	-17,424	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.23
33.24 PART B OFFSET A8-13	A	-532,416	ADULTS & PEDIATRICS	30.00	0	33.24
33.25 PART B OFFSET A8-13	A	-342,383	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.25
33.26 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33.27 DIAGNOSTIC RADIOLOGY A8-2	B	-2,100	RADIOLOGY-DIAGNOSTIC	54.00	0	33.27
33.28 GEN HOSP - LAB/RADIOLOGY A8-1	B	-400	LABORATORY	60.00	0	33.28
33.29 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.29
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,834,797				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0133

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

Worksheet A-8-1

Date/Time Prepared: 11/27/2018 2:18 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	SALARY & OTHER	1,379,653	1,379,653 1.00
2.00	5.02	DATA PROCESSING	SALARY & OTHER	3,751,141	3,751,141 2.00
3.00	60.00	LABORATORY	SALARY & OTHER	1,600,104	1,600,104 3.00
3.01	5.01	NONPATIENT TELEPHONES		422,068	422,068 3.01
3.02	5.03	PURCHASING RECEIVING AND STO		183,910	183,910 3.02
3.03	13.00	NURSING ADMINISTRATION		60	60 3.03
3.04	52.00	DELIVERY ROOM & LABOR ROOM		1,109,172	1,109,172 3.04
3.05	53.00	ANESTHESIOLOGY		1,429,512	1,429,512 3.05
3.06	91.00	EMERGENCY		2,735,520	2,735,520 3.06
3.07	30.00	ADULTS & PEDIATRICS		532,416	532,416 3.07
3.08	0.00			0	0 3.08
3.09	0.00			0	0 3.09
3.10	0.00			0	0 3.10
3.11	0.00			0	0 3.11
3.12	0.00			0	0 3.12
4.00	5.05	OTHER ADMINISTRATIVE & GENER	SALARY & OTHER	3,288,290	3,288,290 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			16,431,846	16,431,846 5.00

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

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

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

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

6.00	E	SINAI HLTH SYST	100.00	0.00	6.00
7.00			0.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
9.01			0.00	0.00	9.01
10.00			0.00	0.00	10.00
10.01			0.00	0.00	10.01
10.02			0.00	0.00	10.02
10.03			0.00	0.00	10.03
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0133

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

Worksheet A-8-1

Date/Time Prepared:
11/27/2018 2:18 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	0	0		3.02
3.03	0	0		3.03
3.04	0	0		3.04
3.05	0	0		3.05
3.06	0	0		3.06
3.07	0	0		3.07
3.08	0	0		3.08
3.09	0	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.12	0	0		3.12
4.00	0	0		4.00
5.00	0	0		5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
9.01			9.01
10.00			10.00
10.01			10.01
10.02			10.02
10.03			10.03
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0133

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

Worksheet A-8-2

Date/Time Prepared:
11/27/2018 2:18 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	30.00	ADULTS & PEDIATRICS	0	0	0	179,000	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	82,500	0	82,500	179,000	1,533	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	179,000	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	1,554,172	1,554,172	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	1,429,512	1,429,512	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	260,300	0	7.00
8.00	5.05	OTHER ADMINISTRATIVE & GENERAL	52,146	0	52,146	197,500	443	8.00
9.00	91.00	EMERGENCY	2,735,520	2,735,520	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			5,853,850	5,719,204	134,646		1,976	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	131,926	6,596	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	5.05	OTHER ADMINISTRATIVE & GENERAL	42,064	2,103	0	0	0	8.00
9.00	91.00	EMERGENCY	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			173,990	8,699	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	30.00	ADULTS & PEDIATRICS	0	0	0	0		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	131,926	0	0		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0		3.00
4.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,554,172		4.00
5.00	53.00	ANESTHESIOLOGY	0	0	0	1,429,512		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		6.00
7.00	60.00	LABORATORY	0	0	0	0		7.00
8.00	5.05	OTHER ADMINISTRATIVE & GENERAL	0	42,064	10,082	10,082		8.00
9.00	91.00	EMERGENCY	0	0	0	2,735,520		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	173,990	10,082	5,729,286		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,633,744	3,633,744			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,272,491		5,272,491		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	12,202,663	31,500	652	12,234,815	4.00
5.01 00540	NONPATIENT TELEPHONES	986,679	3,887	106,029	75,160	1,171,755
5.02 00550	DATA PROCESSING	2,980,741	22,123	1,560,099	340,529	28,510
5.03 00560	PURCHASING RECEIVING AND STORES	406,047	15,317	0	49,088	17,106
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,624,937	32,223	194	121,102	70,324
5.05 00590	OTHER ADMINISTRATIVE & GENERAL	20,286,279	544,538	18,642	928,778	323,111
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	5,633,339	213,711	52,102	527,654	46,566
8.00 00800	LAUNDRY & LINEN SERVICE	817,098	231,774	0	0	0
9.00 00900	HOUSEKEEPING	1,852,932	0	0	226,757	0
10.00 01000	DIETARY	1,323,489	143,298	23,813	122,744	21,858
11.00 01100	CAFETERIA	808,046	108,561	0	74,100	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	1,017,149	16,762	257,760	203,781	1,901
14.00 01400	CENTRAL SERVICES & SUPPLY	488,977	87,132	350,820	42,527	10,454
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,347,300	33,668	4,256	192,535	77,927
17.00 01700	SOCIAL SERVICE	1,332,142	0	0	279,451	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	16,305,832	644,933	160,346	3,229,730	217,625
31.00 03100	INTENSIVE CARE UNIT	4,396,880	179,610	103,972	779,356	19,957
41.00 04100	SUBPROVIDER - I RF	273,187	97,102	19,895	55,908	29,460
43.00 04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,675,684	226,355	353,092	627,593	84,579
51.00 05100	RECOVERY ROOM	356,789	15,880	13,709	74,649	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	1,783,969	142,474	203,590	359,421	0
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,051,857	197,166	1,077,933	369,655	87,430
54.02 03630	ULTRA SOUND	745,945	7,658	1,053	147,426	0
56.00 05600	RADIOISOTOPE	528,827	16,617	110,984	58,706	0
57.00 05700	CT SCAN	834,217	14,739	228,102	127,855	0
59.00 05900	CARDIAC CATHETERIZATION	395,997	0	33,491	62,062	6,652
60.00 06000	LABORATORY	4,792,932	125,713	69,447	316,263	39,914
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1,680,647	22,975	97,185	310,877	0
66.00 06600	PHYSICAL THERAPY	550,067	64,446	2,581	113,940	10,454
67.00 06700	OCCUPATIONAL THERAPY	425,440	27,165	0	88,870	0
68.00 06800	SPEECH PATHOLOGY	262,057	21,675	0	40,399	0
69.00 06900	ELECTROCARDIOLOGY	579,474	22,397	193,945	114,302	0
70.00 07000	ELECTROENCEPHALOGRAPHY	59,069	27,194	5,134	12,277	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,592,853	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	1,507,442	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	5,184,834	32,512	79,304	479,515	20,907
74.00 07400	RENAL DIALYSIS	740,318	0	34,364	118,117	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
91.00 09100	EMERGENCY	8,401,301	207,354	109,997	1,563,688	55,119
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.20 09921	OPT	0	0	0	0	0
99.30 09931	OOT	0	0	0	0	0
99.40 09941	OSP	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	122,139,671	3,578,459	5,272,491	12,234,815	1,169,854
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,981	0	0	1,901
190.01 19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	SEASON HOSPICE	0	29,304	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	0		0 201.00
202.00 TOTAL (sum lines 118 through 201)	122,139,671	3,633,744	5,272,491	12,234,815	1,171,755	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description			DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE & GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES						5.01
5.02	00550	DATA PROCESSING	4,932,002					5.02
5.03	00560	PURCHASING RECEIVING AND STORES	62,178	549,736				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,043,658	1,852	3,894,290			5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	1,342,637	14,312	0	23,458,297	23,458,297	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	56,737	53,676	0	6,583,785	1,565,084	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,971	58,212	0	1,118,055	265,782	8.00
9.00	00900	HOUSEKEEPING	0	12,916	0	2,092,605	497,450	9.00
10.00	01000	DIETARY	0	22,646	0	1,657,848	394,100	10.00
11.00	01100	CAFETERIA	0	0	0	990,707	235,509	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,924	12,185	0	1,513,462	359,777	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	34,148	20,483	0	1,034,541	245,929	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	333,897	331	0	1,989,914	473,038	16.00
17.00	01700	SOCIAL SERVICE	0	134	0	1,611,727	383,137	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	664,892	21,605	602,310	21,847,273	5,193,449	30.00
31.00	03100	INTENSIVE CARE UNIT	139,806	6,688	150,154	5,776,423	1,373,160	31.00
41.00	04100	SUBPROVIDER - IIRF	52,571	1,015	6,241	535,379	127,269	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	210,116	112,646	238,080	5,528,145	1,314,140	50.00
51.00	05100	RECOVERY ROOM	0	204	31,699	492,930	117,178	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71,461	2,733	57,318	2,620,966	623,051	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,974	25,742	174,219	4,140,976	984,385	54.00
54.02	03630	ULTRA SOUND	0	2,808	97,992	1,002,882	238,403	54.02
56.00	05600	RADIOISOTOPE	24,986	17,213	30,475	787,808	187,276	56.00
57.00	05700	CT SCAN	0	15,846	338,463	1,559,222	370,655	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	19,899	16,273	534,374	127,030	59.00
60.00	06000	LABORATORY	0	70,716	434,696	5,849,681	1,390,574	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	33,155	14,128	161,625	2,320,592	551,646	65.00
66.00	06600	PHYSICAL THERAPY	17,126	780	15,846	775,240	184,289	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,324	189	18,881	564,869	134,280	67.00
68.00	06800	SPEECH PATHOLOGY	9,020	4,886	9,266	347,303	82,560	68.00
69.00	06900	ELECTROCARDIOLOGY	91,985	6,135	114,863	1,123,101	266,981	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	31	3,317	107,022	25,441	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	120,563	3,713,416	882,746	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	41,225	1,548,667	368,146	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	236,116	8,041	248,043	6,289,272	1,495,073	73.00
74.00	07400	RENAL DIALYSIS	9,395	9,990	26,161	938,345	223,061	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	321,925	11,694	956,580	11,627,658	2,764,104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,932,002	549,736	3,894,290	122,082,485	23,444,703	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	27,882	6,628	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	29,304	6,966	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,932,002	549,736	3,894,290	122,139,671	23,458,297	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	8,148,869			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	681,729	2,065,566		8.00
9.00	00900	HOUSEKEEPING	0	0	0	2,590,055	9.00
10.00	01000	DIETARY	0	421,490	0	146,198	10.00
11.00	01100	CAFETERIA	0	319,316	0	110,758	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	49,302	0	17,101	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	256,286	0	88,895	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	99,029	0	34,349	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,896,982	749,673	657,991	2,322,877
31.00	03100	INTENSIVE CARE UNIT	0	528,297	128,591	183,245	262,704
41.00	04100	SUBPROVIDER - I RF	0	285,612	28,559	99,068	34,055
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	665,791	95,894	230,936	0
51.00	05100	RECOVERY ROOM	0	46,709	15,054	16,202	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	419,068	97,455	145,358	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	579,937	108,710	201,157	0
54.02	03630	ULTRA SOUND	0	22,526	0	7,813	0
56.00	05600	RADIOISOTOPE	0	48,877	6,999	16,954	0
57.00	05700	CT SCAN	0	43,352	21,595	15,037	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	4,048	0	0
60.00	06000	LABORATORY	0	369,766	0	128,257	0
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	67,578	0	23,440	0
66.00	06600	PHYSICAL THERAPY	0	189,558	5,568	65,750	0
67.00	06700	OCCUPATIONAL THERAPY	0	79,903	0	27,715	0
68.00	06800	SPEECH PATHOLOGY	0	63,753	0	22,113	0
69.00	06900	ELECTROCARDIOLOGY	0	65,878	2,617	22,850	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	79,988	0	27,745	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	95,629	0	33,170	0
74.00	07400	RENAL DIALYSIS	0	0	30,279	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	609,901	770,524	211,550	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.20	09921	OPT	0	0	0	0	0
99.30	09931	OOT	0	0	0	0	0
99.40	09941	OSP	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	7,986,257	2,065,566	2,533,652	2,619,636
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	76,418	0	26,506	0
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	SEASON HOSPICE	0	86,194	0	29,897	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)	0	8,148,869	2,065,566	2,590,055	2,619,636

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,656,290					11.00
12.00	01200	0	0				12.00
13.00	01300	65,470	0	2,005,112			13.00
14.00	01400	15,549	0	0	1,641,200		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	32,917	0	0	0	0	16.00
17.00	01700	44,487	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	578,335	0	1,058,539	0	0	30.00
31.00	03100	106,803	0	171,532	0	0	31.00
41.00	04100	8,490	0	14,927	0	0	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	104,426	0	184,092	0	0	50.00
51.00	05100	8,902	0	15,604	0	0	51.00
52.00	05200	50,988	0	89,208	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	55,912	0	0	0	0	54.00
54.02	03630	18,823	0	0	0	0	54.02
56.00	05600	6,355	0	0	0	0	56.00
57.00	05700	19,794	0	0	0	0	57.00
59.00	05900	9,897	0	0	0	0	59.00
60.00	06000	59,090	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	51,619	0	0	0	0	65.00
66.00	06600	17,392	0	0	0	0	66.00
67.00	06700	12,177	0	0	0	0	67.00
68.00	06800	5,725	0	0	0	0	68.00
69.00	06900	24,403	0	0	0	0	69.00
70.00	07000	2,595	0	0	0	0	70.00
71.00	07100	0	0	0	1,157,380	0	71.00
72.00	07200	0	0	0	483,820	0	72.00
73.00	07300	61,200	0	0	0	0	73.00
74.00	07400	15,646	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	279,295	0	471,210	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00							118.00
		1,656,290	0	2,005,112	1,641,200	0	
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,656,290	0	2,005,112	1,641,200	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,629,247				16.00
17.00	01700	SOCIAL SERVICE	0	2,039,351			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	406,668	1,529,513	0	36,241,300	30.00
31.00	03100	INTENSIVE CARE UNIT	101,381	285,509	0	8,917,645	31.00
41.00	04100	SUBPROVIDER - I RF	4,214	0	0	1,137,573	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	160,747	0	0	8,284,171	50.00
51.00	05100	RECOVERY ROOM	21,403	0	0	733,982	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	38,700	163,148	0	4,247,942	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	117,629	0	0	6,188,706	54.00
54.02	03630	ULTRA SOUND	66,162	0	0	1,356,609	54.02
56.00	05600	RADIO SOTOPE	20,576	0	0	1,074,845	56.00
57.00	05700	CT SCAN	228,524	0	0	2,258,179	57.00
59.00	05900	CARDIAC CATHETERIZATION	10,987	0	0	686,336	59.00
60.00	06000	LABORATORY	293,498	0	0	8,090,866	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	109,126	0	0	3,124,001	65.00
66.00	06600	PHYSICAL THERAPY	10,699	0	0	1,248,496	66.00
67.00	06700	OCCUPATIONAL THERAPY	12,748	0	0	831,692	67.00
68.00	06800	SPEECH PATHOLOGY	6,256	0	0	527,710	68.00
69.00	06900	ELECTROCARDIOLOGY	77,554	0	0	1,583,384	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,240	0	0	245,031	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	81,402	0	0	5,834,944	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,834	0	0	2,428,467	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	167,474	0	0	8,141,818	73.00
74.00	07400	RENAL DIALYSIS	17,664	0	0	1,224,995	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	645,761	61,181	0	17,441,184	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,629,247	2,039,351	0	121,849,876	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	137,434	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	152,361	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
202.00 TOTAL (sum lines 118 through 201)	16.00 2,629,247	17.00 2,039,351	19.00 0	24.00 122,139,671	25.00 0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0133

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

Worksheet B
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	5.05
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
41.00	04100	SUBPROVIDER - IRF	41.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	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
54.02	03630	ULTRA SOUND	54.02
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	62.30
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
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
99.20	09921	OPT	99.20
99.30	09931	OOT	99.30
99.40	09941	OSP	99.40
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
194.00	07950	SEASON HOSPICE	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

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

Worksheet B
Part II
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	31,500	652	32,152	4.00
5.01 00540	NONPATIENT TELEPHONES	0	3,887	106,029	109,916	5.01
5.02 00550	DATA PROCESSING	0	22,123	1,560,099	1,582,222	5.02
5.03 00560	PURCHASING RECEIVING AND STORES	0	15,317	0	15,317	5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	32,223	194	32,417	5.04
5.05 00590	OTHER ADMINISTRATIVE & GENERAL	0	544,538	18,642	563,180	5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	0	213,711	52,102	265,813	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	231,774	0	231,774	8.00
9.00 00900	HOUSEKEEPING	0	0	0	0	9.00
10.00 01000	DIETARY	0	143,298	23,813	167,111	10.00
11.00 01100	CAFETERIA	0	108,561	0	108,561	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	16,762	257,760	274,522	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	87,132	350,820	437,952	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	33,668	4,256	37,924	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	644,933	160,346	805,279	30.00
31.00 03100	INTENSIVE CARE UNIT	0	179,610	103,972	283,582	31.00
41.00 04100	SUBPROVIDER - IIRF	0	97,102	19,895	116,997	41.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	226,355	353,092	579,447	50.00
51.00 05100	RECOVERY ROOM	0	15,880	13,709	29,589	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	142,474	203,590	346,064	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	197,166	1,077,933	1,275,099	54.00
54.02 03630	ULTRA SOUND	0	7,658	1,053	8,711	54.02
56.00 05600	RADIOISOTOPE	0	16,617	110,984	127,601	56.00
57.00 05700	CT SCAN	0	14,739	228,102	242,841	57.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	33,491	33,491	59.00
60.00 06000	LABORATORY	0	125,713	69,447	195,160	60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	0	22,975	97,185	120,160	65.00
66.00 06600	PHYSICAL THERAPY	0	64,446	2,581	67,027	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	27,165	0	27,165	67.00
68.00 06800	SPEECH PATHOLOGY	0	21,675	0	21,675	68.00
69.00 06900	ELECTROCARDIOLOGY	0	22,397	193,945	216,342	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	27,194	5,134	32,328	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	32,512	79,304	111,816	73.00
74.00 07400	RENAL DIALYSIS	0	0	34,364	34,364	74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	207,354	109,997	317,351	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.20 09921	OPT	0	0	0	0	99.20
99.30 09931	OOT	0	0	0	0	99.30
99.40 09941	OSP	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,578,459	5,272,491	8,850,950	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25,981	0	25,981	190.00
190.01 19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
194.00 07950	SEASON HOSPICE	0	29,304	0	29,304	194.00
200.00	Cross Foot Adjustments				0	200.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	3,633,744	5,272,491	8,906,235	32,152	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0133		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/27/2018 2:18 pm	
Cost Center Description			NONPATIENT TELEPHONES	DATA PROCESSING	PURCHASING RECEIVING AND STORES	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE & GENERAL	
			5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	NONPATIENT TELEPHONES	110,114					5.01
5.02	00550	DATA PROCESSING	2,679	1,585,797				5.02
5.03	00560	PURCHASING RECEIVING AND STORES	1,608	19,992	37,046			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	6,609	335,570	125	375,039		5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	30,364	431,699	965	0	1,028,651	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,376	18,243	3,617	0	68,629	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,528	3,923	0	11,655	8.00
9.00	00900	HOUSEKEEPING	0	0	870	0	21,813	9.00
10.00	01000	DIETARY	2,054	0	1,526	0	17,281	10.00
11.00	01100	CAFETERIA	0	0	0	0	10,327	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	179	1,262	821	0	15,776	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	982	10,980	1,380	0	10,784	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,323	107,359	22	0	20,743	16.00
17.00	01700	SOCIAL SERVICE	0	0	9	0	16,801	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,451	213,784	1,456	58,016	227,735	30.00
31.00	03100	INTENSIVE CARE UNIT	1,875	44,952	451	14,463	60,213	31.00
41.00	04100	SUBPROVIDER - IIRF	2,768	16,903	68	601	5,581	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,948	67,559	7,591	22,933	57,625	50.00
51.00	05100	RECOVERY ROOM	0	0	14	3,053	5,138	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	22,977	184	5,521	27,321	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,216	50,472	1,735	16,781	43,166	54.00
54.02	03630	ULTRA SOUND	0	0	189	9,439	10,454	54.02
56.00	05600	RADIOISOTOPE	0	8,034	1,160	2,935	8,212	56.00
57.00	05700	CT SCAN	0	0	1,068	32,602	16,253	57.00
59.00	05900	CARDIAC CATHETERIZATION	625	0	1,341	1,567	5,570	59.00
60.00	06000	LABORATORY	3,751	0	4,766	41,871	60,977	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	10,661	952	15,568	24,190	65.00
66.00	06600	PHYSICAL THERAPY	982	5,507	53	1,526	8,081	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,390	13	1,819	5,888	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,900	329	893	3,620	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,576	413	11,064	11,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	2	320	1,116	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	11,613	38,709	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,971	16,143	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,965	75,919	542	23,892	65,559	73.00
74.00	07400	RENAL DIALYSIS	0	3,021	673	2,520	9,781	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,180	103,509	788	92,071	121,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	109,935	1,585,797	37,046	375,039	1,028,055	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	179	0	0	0	291	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	SEASON HOSPICE	0	0	0	0	305	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)	110,114	1,585,797	37,046	375,039	1,028,651	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/27/2018 2:18 pm		
Cost Center Description			MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			6.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	362,066			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,290	281,170		8.00
9.00	00900	HOUSEKEEPING	0	0	0	23,279	9.00
10.00	01000	DIETARY	0	18,727	0	1,314	208,336
11.00	01100	CAFETERIA	0	14,188	0	995	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	2,191	0	154	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,387	0	799	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,400	0	309	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	84,286	102,047	5,915	184,736
31.00	03100	INTENSIVE CARE UNIT	0	23,473	17,504	1,647	20,892
41.00	04100	SUBPROVIDER - I RF	0	12,690	3,887	890	2,708
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	29,582	13,053	2,076	0
51.00	05100	RECOVERY ROOM	0	2,075	2,049	146	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,620	13,266	1,306	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,767	14,798	1,808	0
54.02	03630	ULTRA SOUND	0	1,001	0	70	0
56.00	05600	RADIOISOTOPE	0	2,172	953	152	0
57.00	05700	CT SCAN	0	1,926	2,940	135	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	551	0	0
60.00	06000	LABORATORY	0	16,429	0	1,153	0
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	3,003	0	211	0
66.00	06600	PHYSICAL THERAPY	0	8,422	758	591	0
67.00	06700	OCCUPATIONAL THERAPY	0	3,550	0	249	0
68.00	06800	SPEECH PATHOLOGY	0	2,833	0	199	0
69.00	06900	ELECTROCARDIOLOGY	0	2,927	356	205	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	3,554	0	249	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,249	0	298	0
74.00	07400	RENAL DIALYSIS	0	0	4,122	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	27,099	104,886	1,901	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.20	09921	OPT	0	0	0	0	0
99.30	09931	OOT	0	0	0	0	0
99.40	09941	OSP	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	354,841	281,170	22,772	208,336
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,395	0	238	0
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00	07950	SEASON HOSPICE	0	3,830	0	269	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)	0	362,066	281,170	23,279	208,336

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

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

Worksheet B
Part II
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	134,266					11.00
12.00	01200	0	0				12.00
13.00	01300	5,307	0	300,748			13.00
14.00	01400	1,260	0	0	475,636		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	2,668	0	0	0	0	16.00
17.00	01700	3,606	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	46,886	0	158,772	0	0	30.00
31.00	03100	8,658	0	25,728	0	0	31.00
41.00	04100	688	0	2,239	0	0	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,465	0	27,612	0	0	50.00
51.00	05100	722	0	2,340	0	0	51.00
52.00	05200	4,133	0	13,380	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	4,532	0	0	0	0	54.00
54.02	03630	1,526	0	0	0	0	54.02
56.00	05600	515	0	0	0	0	56.00
57.00	05700	1,605	0	0	0	0	57.00
59.00	05900	802	0	0	0	0	59.00
60.00	06000	4,790	0	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	4,184	0	0	0	0	65.00
66.00	06600	1,410	0	0	0	0	66.00
67.00	06700	987	0	0	0	0	67.00
68.00	06800	464	0	0	0	0	68.00
69.00	06900	1,978	0	0	0	0	69.00
70.00	07000	210	0	0	0	0	70.00
71.00	07100	0	0	0	335,420	0	71.00
72.00	07200	0	0	0	140,216	0	72.00
73.00	07300	4,961	0	0	0	0	73.00
74.00	07400	1,268	0	0	0	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	22,641	0	70,677	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		134,266	0	300,748	475,636	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		134,266	0	300,748	475,636	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0133

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

Worksheet B
Part II
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00540	NONPATIENT TELEPHONES					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00560	PURCHASING RECEIVING AND STORES					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	181,254				16.00
17.00	01700	SOCIAL SERVICE	0	21,151			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,989	15,863		1,961,684	0 30.00
31.00	03100	INTENSIVE CARE UNIT	6,977	2,961		515,426	0 31.00
41.00	04100	SUBPROVIDER - I RF	290	0		166,457	0 41.00
43.00	04300	NURSERY	0	0		0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,063	0		836,604	0 50.00
51.00	05100	RECOVERY ROOM	1,473	0		46,795	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,663	1,692		458,072	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0		0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,096	0		1,451,442	0 54.00
54.02	03630	ULTRA SOUND	4,554	0		36,332	0 54.02
56.00	05600	RADIOISOTOPE	1,416	0		153,304	0 56.00
57.00	05700	CT SCAN	15,728	0		315,434	0 57.00
59.00	05900	CARDIAC CATHETERIZATION	756	0		44,866	0 59.00
60.00	06000	LABORATORY	20,200	0		349,929	0 60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0		0	0 62.30
65.00	06500	RESPIRATORY THERAPY	7,511	0		187,258	0 65.00
66.00	06600	PHYSICAL THERAPY	736	0		95,393	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	877	0		42,172	0 67.00
68.00	06800	SPEECH PATHOLOGY	431	0		33,450	0 68.00
69.00	06900	ELECTROCARDIOLOGY	5,338	0		280,207	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	154	0		37,965	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,602	0		391,344	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,916	0		162,246	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,526	0		301,988	0 73.00
74.00	07400	RENAL DIALYSIS	1,216	0		57,276	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0		0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		0	0 76.98
76.99	07699	LITHOTRIPSY	0	0		0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0		0	0 90.00
91.00	09100	EMERGENCY	44,742	635		916,799	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0		0	0 94.00
99.20	09921	OPT	0	0		0	0 99.20
99.30	09931	OOT	0	0		0	0 99.30
99.40	09941	OSP	0	0		0	0 99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,254	21,151	0	8,842,443	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		30,084	0 190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	0		0	0 190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0 192.00
194.00	07950	SEASON HOSPICE	0	0		33,708	0 194.00
200.00		Cross Foot Adjustments			0	0	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0133			Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/27/2018 2:18 pm	
Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
202.00 TOTAL (sum lines 118 through 201)	16.00 181,254	17.00 21,151	19.00 0	24.00 8,906,235	25.00 0			202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/27/2018 2:18 pm
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00540	NONPATIENT TELEPHONES	5.01
5.02	00550	DATA PROCESSING	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL	5.05
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,961,684
31.00	03100	INTENSIVE CARE UNIT	515,426
41.00	04100	SUBPROVIDER - IRF	166,457
43.00	04300	NURSERY	0
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	836,604
51.00	05100	RECOVERY ROOM	46,795
52.00	05200	DELIVERY ROOM & LABOR ROOM	458,072
53.00	05300	ANESTHESIOLOGY	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,442
54.02	03630	ULTRA SOUND	36,332
56.00	05600	RADIOISOTOPE	153,304
57.00	05700	CT SCAN	315,434
59.00	05900	CARDIAC CATHETERIZATION	44,866
60.00	06000	LABORATORY	349,929
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0
65.00	06500	RESPIRATORY THERAPY	187,258
66.00	06600	PHYSICAL THERAPY	95,393
67.00	06700	OCCUPATIONAL THERAPY	42,172
68.00	06800	SPEECH PATHOLOGY	33,450
69.00	06900	ELECTROCARDIOLOGY	280,207
70.00	07000	ELECTROENCEPHALOGRAPHY	37,965
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	391,344
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,246
73.00	07300	DRUGS CHARGED TO PATIENTS	301,988
74.00	07400	RENAL DIALYSIS	57,276
76.97	07697	CARDIAC REHABILITATION	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0
76.99	07699	LITHOTRIPSY	0
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0
91.00	09100	EMERGENCY	916,799
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0
99.20	09921	OPT	0
99.30	09931	OOT	0
99.40	09941	OSP	0
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,842,443
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,084
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0
194.00	07950	SEASON HOSPICE	33,708
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	8,906,235

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	251,475				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		3,039,806			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,180	376	57,559,034		4.00
5.01 00540	NONPATIENT TELEPHONES	269	61,130	353,591	1,233	5.01
5.02 00550	DATA PROCESSING	1,531	899,461	1,602,028	30	1,182,745 5.02
5.03 00560	PURCHASING RECEIVING AND STORES	1,060	0	230,935	18	14,911 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,230	112	569,726	74	250,280 5.04
5.05 00590	OTHER ADMINISTRATIVE & GENERAL	37,685	10,748	4,369,464	340	321,978 5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	14,790	30,039	2,482,364	49	13,606 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	16,040	0	0	0	2,631 8.00
9.00 00900	HOUSEKEEPING	0	0	1,066,787	0	0 9.00
10.00 01000	DIETARY	9,917	13,729	577,455	23	0 10.00
11.00 01100	CAFETERIA	7,513	0	348,607	0	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	1,160	148,609	958,692	2	941 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,030	202,262	200,068	11	8,189 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,330	2,454	905,787	82	80,072 16.00
17.00 01700	SOCIAL SERVICE	0	0	1,314,685	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	44,633	92,446	15,194,335	229	159,448 30.00
31.00 03100	INTENSIVE CARE UNIT	12,430	59,944	3,666,504	21	33,527 31.00
41.00 04100	SUBPROVIDER - I RF	6,720	11,470	263,019	31	12,607 41.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	15,665	203,572	2,952,533	89	50,388 50.00
51.00 05100	RECOVERY ROOM	1,099	7,904	351,187	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,860	117,378	1,690,908	0	17,137 52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	13,645	621,472	1,739,054	92	37,644 54.00
54.02 03630	ULTRA SOUND	530	607	693,568	0	0 54.02
56.00 05600	RADIOISOTOPE	1,150	63,987	276,185	0	5,992 56.00
57.00 05700	CT SCAN	1,020	131,510	601,498	0	0 57.00
59.00 05900	CARDIAC CATHETERIZATION	0	19,309	291,974	7	0 59.00
60.00 06000	LABORATORY	8,700	40,039	1,487,870	42	0 60.00
62.30 06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	1,590	56,031	1,462,531	0	7,951 65.00
66.00 06600	PHYSICAL THERAPY	4,460	1,488	536,034	11	4,107 66.00
67.00 06700	OCCUPATIONAL THERAPY	1,880	0	418,090	0	1,037 67.00
68.00 06800	SPEECH PATHOLOGY	1,500	0	190,059	0	2,163 68.00
69.00 06900	ELECTROCARDIOLOGY	1,550	111,817	537,738	0	22,059 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,882	2,960	57,759	0	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,250	45,722	2,255,893	22	56,623 73.00
74.00 07400	RENAL DIALYSIS	0	19,812	555,684	0	2,253 74.00
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	14,350	63,418	7,356,422	58	77,201 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
99.20 09921	OPT	0	0	0	0	0 99.20
99.30 09931	OOT	0	0	0	0	0 99.30
99.40 09941	OSP	0	0	0	0	0 99.40
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	247,649	3,039,806	57,559,034	1,231	1,182,745 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,798	0	0	2	0 190.00
190.01 19001	SISTERS & PRIESTS MAINTENANCE	0	0	0	0	0 190.01
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
194.00 07950	SEASON HOSPICE	2,028	0	0	0	0 194.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	NONPATIENT TELEPHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,633,744	5,272,491	12,234,815	1,171,755	4,932,002	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.449723	1.734483	0.212561	950.328467	4.169962	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			32,152	110,114	1,585,797	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000559	89.305758	1.340777	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: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COSTED REQUISITION)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560	7,716,474					5.03
5.04	00580	25,998	599,220,617				5.04
5.05	00590	200,898	0	-23,458,297	98,681,374		5.05
6.00	00600	0	0	0	0	0	6.00
7.00	00700	753,430	0	0	6,583,785	0	7.00
8.00	00800	817,098	0	0	1,118,055	0	8.00
9.00	00900	181,302	0	0	2,092,605	0	9.00
10.00	01000	317,881	0	0	1,657,848	0	10.00
11.00	01100	0	0	0	990,707	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	171,042	0	0	1,513,462	0	13.00
14.00	01400	287,518	0	0	1,034,541	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	4,649	0	0	1,989,914	0	16.00
17.00	01700	1,887	0	0	1,611,727	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	303,265	92,677,288	0	21,847,273	0	30.00
31.00	03100	93,871	23,104,104	0	5,776,423	0	31.00
41.00	04100	14,250	960,233	0	535,379	0	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	1,581,177	36,633,396	0	5,528,145	0	50.00
51.00	05100	2,865	4,877,535	0	492,930	0	51.00
52.00	05200	38,361	8,819,510	0	2,620,966	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	361,325	26,807,075	0	4,140,976	0	54.00
54.02	03630	39,411	15,077,970	0	1,002,882	0	54.02
56.00	05600	241,616	4,689,241	0	787,808	0	56.00
57.00	05700	222,427	52,079,214	0	1,559,222	0	57.00
59.00	05900	279,316	2,503,958	0	534,374	0	59.00
60.00	06000	992,610	66,886,621	0	5,849,681	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	198,309	24,869,247	0	2,320,592	0	65.00
66.00	06600	10,950	2,438,224	0	775,240	0	66.00
67.00	06700	2,646	2,905,195	0	564,869	0	67.00
68.00	06800	68,587	1,425,802	0	347,303	0	68.00
69.00	06900	86,117	17,674,002	0	1,123,101	0	69.00
70.00	07000	430	510,432	0	107,022	0	70.00
71.00	07100	0	18,551,046	0	3,713,416	0	71.00
72.00	07200	0	6,343,252	0	1,548,667	0	72.00
73.00	07300	112,875	38,166,280	0	6,289,272	0	73.00
74.00	07400	140,223	4,025,451	0	938,345	0	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	164,140	147,195,541	0	11,627,658	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		7,716,474	599,220,617	-23,458,297	98,624,188	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	27,882	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	29,304	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		PURCHASING RECEIVING AND STORES (COSTED REQUISITION)	CASHIERING/ACC OUNTS RECEIVABLE (GROSS REVENUE)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	549,736	3,894,290		23,458,297		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.071242	0.006499		0.237718	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	37,046	375,039		1,028,651		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.004801	0.000626		0.010424	0.000000	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: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	191,730	1,241,355				8.00
9.00	00900	16,040		175,690			9.00
10.00	01000	0		9,917	163,847		10.00
11.00	01100	9,917		0	0	68,281	11.00
12.00	01200	7,513		7,513	0	0	12.00
13.00	01300	0		0	0	0	13.00
14.00	01400	1,160		1,160	0	2,699	14.00
15.00	01500	6,030		6,030	0	641	15.00
16.00	01600	0		0	0	0	16.00
17.00	01700	2,330		2,330	0	1,357	17.00
19.00	01900	0		0	0	1,834	19.00
19.00	01900	0		0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,633	450,535	44,633	145,286	23,842	30.00
31.00	03100	12,430	77,280	12,430	16,431	4,403	31.00
41.00	04100	6,720	17,163	6,720	2,130	350	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	15,665	57,630	15,665	0	4,305	50.00
51.00	05100	1,099	9,047	1,099	0	367	51.00
52.00	05200	9,860	58,568	9,860	0	2,102	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	13,645	65,332	13,645	0	2,305	54.00
54.02	03630	530	0	530	0	776	54.02
56.00	05600	1,150	4,206	1,150	0	262	56.00
57.00	05700	1,020	12,978	1,020	0	816	57.00
59.00	05900	0	2,433	0	0	408	59.00
60.00	06000	8,700	0	8,700	0	2,436	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,590	0	1,590	0	2,128	65.00
66.00	06600	4,460	3,346	4,460	0	717	66.00
67.00	06700	1,880	0	1,880	0	502	67.00
68.00	06800	1,500	0	1,500	0	236	68.00
69.00	06900	1,550	1,573	1,550	0	1,006	69.00
70.00	07000	1,882	0	1,882	0	107	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,250	0	2,250	0	2,523	73.00
74.00	07400	0	18,197	0	0	645	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	14,350	463,067	14,350	0	11,514	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		187,904	1,241,355	171,864	163,847	68,281	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,798	0	1,798	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	2,028	0	2,028	0	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
		7.00	8.00	9.00	10.00	11.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	8,148,869	2,065,566	2,590,055	2,619,636	1,656,290	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	42.501794	1.663961	14.742188	15.988306	24.256968	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	362,066	281,170	23,279	208,336	134,266	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.888416	0.226502	0.132500	1.271528	1.966374	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: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00540						5.01
5.02	00550						5.02
5.03	00560						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200	0					12.00
13.00	01300	0	974,149				13.00
14.00	01400	0	0	5,113,509			14.00
15.00	01500	0	0	0	0		15.00
16.00	01600	0	0	0	0	599,220,617	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	0	514,273	0	0	92,677,288	30.00
31.00	03100	0	83,336	0	0	23,104,104	31.00
41.00	04100	0	7,252	0	0	960,233	41.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	89,438	0	0	36,633,396	50.00
51.00	05100	0	7,581	0	0	4,877,535	51.00
52.00	05200	0	43,340	0	0	8,819,510	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	0	0	0	26,807,075	54.00
54.02	03630	0	0	0	0	15,077,970	54.02
56.00	05600	0	0	0	0	4,689,241	56.00
57.00	05700	0	0	0	0	52,079,214	57.00
59.00	05900	0	0	0	0	2,503,958	59.00
60.00	06000	0	0	0	0	66,886,621	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	0	0	0	24,869,247	65.00
66.00	06600	0	0	0	0	2,438,224	66.00
67.00	06700	0	0	0	0	2,905,195	67.00
68.00	06800	0	0	0	0	1,425,802	68.00
69.00	06900	0	0	0	0	17,674,002	69.00
70.00	07000	0	0	0	0	510,432	70.00
71.00	07100	0	0	3,606,067	0	18,551,046	71.00
72.00	07200	0	0	1,507,442	0	6,343,252	72.00
73.00	07300	0	0	0	0	38,166,280	73.00
74.00	07400	0	0	0	0	4,025,451	74.00
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
91.00	09100	0	228,929	0	0	147,195,541	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.20	09921	0	0	0	0	0	99.20
99.30	09931	0	0	0	0	0	99.30
99.40	09941	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		0	974,149	5,113,509	0	599,220,617	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	0	0	0	0	192.00
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1

Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		12.00	13.00	14.00	15.00	16.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	0	2,005,112	1,641,200	0	2,629,247	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	2.058322	0.320954	0.000000	0.004388	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	300,748	475,636	0	181,254	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.308729	0.093016	0.000000	0.000302	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: 14-0133

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

Worksheet B-1
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00540	NONPATIENT TELEPHONES		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00560	PURCHASING RECEIVING AND STORES		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE		5.04
5.05	00590	OTHER ADMINISTRATIVE & GENERAL		5.05
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	75	30.00
31.00	03100	INTENSIVE CARE UNIT	14	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.02	03630	ULTRA SOUND	0	54.02
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	3	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	94.00
99.20	09921	OPT	0	99.20
99.30	09931	OOT	0	99.30
99.40	09941	OSP	0	99.40
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	SISTERS & PRIESTS MAINTENANCE	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	SEASON HOSPICE	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0133

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

Worksheet B-1
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2,039,351	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	20,393.510000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	21,151	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	211.510000	0.000000	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: 14-0133

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

Worksheet C
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	Hospital		
					RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	36,241,300		36,241,300	0	36,241,300	30.00
31.00	03100 INTENSIVE CARE UNIT	8,917,645		8,917,645	0	8,917,645	31.00
41.00	04100 SUBPROVIDER - I RF	1,137,573		1,137,573	0	1,137,573	41.00
43.00	04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	8,284,171		8,284,171	0	8,284,171	50.00
51.00	05100 RECOVERY ROOM	733,982		733,982	0	733,982	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,247,942		4,247,942	0	4,247,942	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,188,706		6,188,706	0	6,188,706	54.00
54.02	03630 ULTRASOUND	1,356,609		1,356,609	0	1,356,609	54.02
56.00	05600 RADIOISOTOPE	1,074,845		1,074,845	0	1,074,845	56.00
57.00	05700 CT SCAN	2,258,179		2,258,179	0	2,258,179	57.00
59.00	05900 CARDIAC CATHETERIZATION	686,336		686,336	0	686,336	59.00
60.00	06000 LABORATORY	8,090,866		8,090,866	0	8,090,866	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	3,124,001	0	3,124,001	0	3,124,001	65.00
66.00	06600 PHYSICAL THERAPY	1,248,496	0	1,248,496	0	1,248,496	66.00
67.00	06700 OCCUPATIONAL THERAPY	831,692	0	831,692	0	831,692	67.00
68.00	06800 SPEECH PATHOLOGY	527,710	0	527,710	0	527,710	68.00
69.00	06900 ELECTROCARDIOLOGY	1,583,384		1,583,384	0	1,583,384	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	245,031		245,031	0	245,031	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,834,944		5,834,944	0	5,834,944	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,428,467		2,428,467	0	2,428,467	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,141,818		8,141,818	0	8,141,818	73.00
74.00	07400 RENAL DIALYSIS	1,224,995		1,224,995	0	1,224,995	74.00
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0		0	0	0	90.00
91.00	09100 EMERGENCY	17,441,184		17,441,184	0	17,441,184	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,095,684		4,095,684	0	4,095,684	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.20	09921 OPT	0		0	0	0	99.20
99.30	09931 OOT	0		0	0	0	99.30
99.40	09941 OSP	0		0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	125,945,560	0	125,945,560	0	125,945,560	200.00
201.00	Less Observation Beds	4,095,684		4,095,684		4,095,684	201.00
202.00	Total (see instructions)	121,849,876	0	121,849,876	0	121,849,876	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

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

Worksheet C
Part I
Date/Time Prepared:
11/27/2018 2:18 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,571,716		84,571,716		30.00
31.00	03100	INTENSIVE CARE UNIT	23,104,104		23,104,104		31.00
41.00	04100	SUBPROVIDER - IRF	960,233		960,233		41.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,690,437	16,942,959	36,633,396	0.226137	50.00
51.00	05100	RECOVERY ROOM	2,423,415	2,454,120	4,877,535	0.150482	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,422,292	1,397,218	8,819,510	0.481653	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,856,060	16,951,015	26,807,075	0.230861	54.00
54.02	03630	ULTRA SOUND	6,588,484	8,489,486	15,077,970	0.089973	54.02
56.00	05600	RADIOISOTOPE	2,807,518	1,881,723	4,689,241	0.229215	56.00
57.00	05700	CT SCAN	22,160,604	29,918,610	52,079,214	0.043360	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,848,211	655,747	2,503,958	0.274100	59.00
60.00	06000	LABORATORY	37,381,936	29,504,685	66,886,621	0.120964	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	23,271,422	1,597,825	24,869,247	0.125617	65.00
66.00	06600	PHYSICAL THERAPY	1,606,976	831,248	2,438,224	0.512051	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,934,348	970,847	2,905,195	0.286278	67.00
68.00	06800	SPEECH PATHOLOGY	1,021,099	404,703	1,425,802	0.370115	68.00
69.00	06900	ELECTROCARDIOLOGY	10,625,771	7,048,231	17,674,002	0.089588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	354,888	155,544	510,432	0.480046	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,548,446	6,002,600	18,551,046	0.314535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,188,168	2,155,084	6,343,252	0.382843	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,335,494	9,830,786	38,166,280	0.213325	73.00
74.00	07400	RENAL DIALYSIS	3,786,578	238,873	4,025,451	0.304312	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	53,633,870	93,561,671	147,195,541	0.118490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,105,572	8,105,572	0.505292	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.20	09921	OPT	0	0	0		99.20
99.30	09931	OOT	0	0	0		99.30
99.40	09941	OSP	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	360,122,070	239,098,547	599,220,617		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	360,122,070	239,098,547	599,220,617		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/27/2018 2:18 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.226137		50.00
51.00	05100 RECOVERY ROOM	0.150482		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.481653		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230861		54.00
54.02	03630 ULTRASOUND	0.089973		54.02
56.00	05600 RADIOISOTOPE	0.229215		56.00
57.00	05700 CT SCAN	0.043360		57.00
59.00	05900 CARDIAC CATHETERIZATION	0.274100		59.00
60.00	06000 LABORATORY	0.120964		60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.125617		65.00
66.00	06600 PHYSICAL THERAPY	0.512051		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286278		67.00
68.00	06800 SPEECH PATHOLOGY	0.370115		68.00
69.00	06900 ELECTROCARDIOLOGY	0.089588		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.480046		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314535		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382843		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213325		73.00
74.00	07400 RENAL DIALYSIS	0.304312		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.118490		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.505292		92.00
	OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
99.20	09921 OPT			99.20
99.30	09931 OOT			99.30
99.40	09941 OSP			99.40
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

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

Worksheet C
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

		Title XIX		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS		36,241,300	0	36,241,300	30.00	
31.00	03100 INTENSIVE CARE UNIT		8,917,645	0	8,917,645	31.00	
41.00	04100 SUBPROVIDER - I RF		1,137,573	0	1,137,573	41.00	
43.00	04300 NURSERY		0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		8,284,171	0	8,284,171	50.00	
51.00	05100 RECOVERY ROOM		733,982	0	733,982	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,247,942	0	4,247,942	52.00	
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC		6,188,706	0	6,188,706	54.00	
54.02	03630 ULTRASOUND		1,356,609	0	1,356,609	54.02	
56.00	05600 RADIOISOTOPE		1,074,845	0	1,074,845	56.00	
57.00	05700 CT SCAN		2,258,179	0	2,258,179	57.00	
59.00	05900 CARDIAC CATHETERIZATION		686,336	0	686,336	59.00	
60.00	06000 LABORATORY		8,090,866	0	8,090,866	60.00	
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.		0	0	0	62.30	
65.00	06500 RESPIRATORY THERAPY	0	3,124,001	0	3,124,001	65.00	
66.00	06600 PHYSICAL THERAPY	0	1,248,496	0	1,248,496	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0	831,692	0	831,692	67.00	
68.00	06800 SPEECH PATHOLOGY	0	527,710	0	527,710	68.00	
69.00	06900 ELECTROCARDIOLOGY		1,583,384	0	1,583,384	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY		245,031	0	245,031	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		5,834,944	0	5,834,944	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		2,428,467	0	2,428,467	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS		8,141,818	0	8,141,818	73.00	
74.00	07400 RENAL DIALYSIS		1,224,995	0	1,224,995	74.00	
76.97	07697 CARDIAC REHABILITATION		0	0	0	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY		0	0	0	76.98	
76.99	07699 LI THOTRI PSY		0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC		0	0	0	90.00	
91.00	09100 EMERGENCY		17,441,184	0	17,441,184	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		4,095,684	0	4,095,684	92.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS		0	0	0	94.00	
99.20	09921 OPT		0	0	0	99.20	
99.30	09931 OOT		0	0	0	99.30	
99.40	09941 OSP		0	0	0	99.40	
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE					113.00	
200.00	Subtotal (see instructions)		125,945,560	0	125,945,560	200.00	
201.00	Less Observation Beds		4,095,684		4,095,684	201.00	
202.00	Total (see instructions)		121,849,876	0	121,849,876	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0133

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

Worksheet C
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	84,571,716		84,571,716		30.00
31.00	03100	INTENSIVE CARE UNIT	23,104,104		23,104,104		31.00
41.00	04100	SUBPROVIDER - IRF	960,233		960,233		41.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,690,437	16,942,959	36,633,396	0.226137	50.00
51.00	05100	RECOVERY ROOM	2,423,415	2,454,120	4,877,535	0.150482	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,422,292	1,397,218	8,819,510	0.481653	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,856,060	16,951,015	26,807,075	0.230861	54.00
54.02	03630	ULTRA SOUND	6,588,484	8,489,486	15,077,970	0.089973	54.02
56.00	05600	RADIOISOTOPE	2,807,518	1,881,723	4,689,241	0.229215	56.00
57.00	05700	CT SCAN	22,160,604	29,918,610	52,079,214	0.043360	57.00
59.00	05900	CARDIAC CATHETERIZATION	1,848,211	655,747	2,503,958	0.274100	59.00
60.00	06000	LABORATORY	37,381,936	29,504,685	66,886,621	0.120964	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	23,271,422	1,597,825	24,869,247	0.125617	65.00
66.00	06600	PHYSICAL THERAPY	1,606,976	831,248	2,438,224	0.512051	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,934,348	970,847	2,905,195	0.286278	67.00
68.00	06800	SPEECH PATHOLOGY	1,021,099	404,703	1,425,802	0.370115	68.00
69.00	06900	ELECTROCARDIOLOGY	10,625,771	7,048,231	17,674,002	0.089588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	354,888	155,544	510,432	0.480046	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,548,446	6,002,600	18,551,046	0.314535	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,188,168	2,155,084	6,343,252	0.382843	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,335,494	9,830,786	38,166,280	0.213325	73.00
74.00	07400	RENAL DIALYSIS	3,786,578	238,873	4,025,451	0.304312	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	53,633,870	93,561,671	147,195,541	0.118490	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,105,572	8,105,572	0.505292	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.20	09921	OPT	0	0	0		99.20
99.30	09931	OOT	0	0	0		99.30
99.40	09941	OSP	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	360,122,070	239,098,547	599,220,617		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	360,122,070	239,098,547	599,220,617		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/27/2018 2:18 pm
		Title XIX	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
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.226137		50.00
51.00	05100 RECOVERY ROOM	0.150482		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.481653		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230861		54.00
54.02	03630 ULTRASOUND	0.089973		54.02
56.00	05600 RADIOISOTOPE	0.229215		56.00
57.00	05700 CT SCAN	0.043360		57.00
59.00	05900 CARDIAC CATHETERIZATION	0.274100		59.00
60.00	06000 LABORATORY	0.120964		60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.125617		65.00
66.00	06600 PHYSICAL THERAPY	0.512051		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286278		67.00
68.00	06800 SPEECH PATHOLOGY	0.370115		68.00
69.00	06900 ELECTROCARDIOLOGY	0.089588		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.480046		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314535		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382843		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213325		73.00
74.00	07400 RENAL DIALYSIS	0.304312		74.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.118490		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.505292		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
99.20	09921 OPT			99.20
99.30	09931 OOT			99.30
99.40	09941 OSP			99.40
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 14-0133

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

Worksheet C Part II Date/Time Prepared: 11/27/2018 2:18 pm

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,284,171	836,604	7,447,567	0	0	50.00
51.00	05100	RECOVERY ROOM	733,982	46,795	687,187	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,247,942	458,072	3,789,870	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,188,706	1,451,442	4,737,264	0	0	54.00
54.02	03630	ULTRA SOUND	1,356,609	36,332	1,320,277	0	0	54.02
56.00	05600	RADIOISOTOPE	1,074,845	153,304	921,541	0	0	56.00
57.00	05700	CT SCAN	2,258,179	315,434	1,942,745	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	686,336	44,866	641,470	0	0	59.00
60.00	06000	LABORATORY	8,090,866	349,929	7,740,937	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,124,001	187,258	2,936,743	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,248,496	95,393	1,153,103	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	831,692	42,172	789,520	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	527,710	33,450	494,260	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,583,384	280,207	1,303,177	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	245,031	37,965	207,066	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,834,944	391,344	5,443,600	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,428,467	162,246	2,266,221	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,141,818	301,988	7,839,830	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,224,995	57,276	1,167,719	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	17,441,184	916,799	16,524,385	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,095,684	221,691	3,873,993	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.20	09921	OPT	0	0	0	0	0	99.20
99.30	09931	OOT	0	0	0	0	0	99.30
99.40	09941	OSP	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	79,649,042	6,420,567	73,228,475	0	0	200.00
201.00		Less Observation Beds	4,095,684	221,691	3,873,993	0	0	201.00
202.00		Total (line 200 minus line 201)	75,553,358	6,198,876	69,354,482	0	0	202.00

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

Provider CCN: 14-0133

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

Worksheet C
Part II
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Title XIX	
					Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8,284,171	36,633,396	0.226137		50.00
51.00	05100 RECOVERY ROOM	733,982	4,877,535	0.150482		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	4,247,942	8,819,510	0.481653		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,188,706	26,807,075	0.230861		54.00
54.02	03630 ULTRA SOUND	1,356,609	15,077,970	0.089973		54.02
56.00	05600 RADIOISOTOPE	1,074,845	4,689,241	0.229215		56.00
57.00	05700 CT SCAN	2,258,179	52,079,214	0.043360		57.00
59.00	05900 CARDIAC CATHETERIZATION	686,336	2,503,958	0.274100		59.00
60.00	06000 LABORATORY	8,090,866	66,886,621	0.120964		60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	3,124,001	24,869,247	0.125617		65.00
66.00	06600 PHYSICAL THERAPY	1,248,496	2,438,224	0.512051		66.00
67.00	06700 OCCUPATIONAL THERAPY	831,692	2,905,195	0.286278		67.00
68.00	06800 SPEECH PATHOLOGY	527,710	1,425,802	0.370115		68.00
69.00	06900 ELECTROCARDIOLOGY	1,583,384	17,674,002	0.089588		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	245,031	510,432	0.480046		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	5,834,944	18,551,046	0.314535		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,428,467	6,343,252	0.382843		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,141,818	38,166,280	0.213325		73.00
74.00	07400 RENAL DIALYSIS	1,224,995	4,025,451	0.304312		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000		76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000		90.00
91.00	09100 EMERGENCY	17,441,184	147,195,541	0.118490		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4,095,684	8,105,572	0.505292		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.20	09921 OPT	0	0	0.000000		99.20
99.30	09931 OOT	0	0	0.000000		99.30
99.40	09941 OSP	0	0	0.000000		99.40
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	79,649,042	490,584,564			200.00
201.00	Less Observation Beds	4,095,684	0			201.00
202.00	Total (line 200 minus line 201)	75,553,358	490,584,564			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part I Date/Time Prepared: 11/27/2018 2:18 pm
Title XVIII			Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,961,684	0	1,961,684	43,907	44.68	30.00
31.00	INTENSIVE CARE UNIT	515,426	0	515,426	4,505	114.41	31.00
41.00	SUBPROVIDER - IRF	166,457	0	166,457	584	285.03	41.00
43.00	NURSERY	0	0	0	874	0.00	43.00
200.00	Total (lines 30 through 199)	2,643,567		2,643,567	49,870		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	11,204	500,595				
31.00	INTENSIVE CARE UNIT	1,551	177,450				
41.00	SUBPROVIDER - IRF	365	104,036				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	13,120	782,081				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0133

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

Worksheet D
Part II
Date/Time Prepared:
11/27/2018 2:18 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	836,604	36,633,396	0.022837	5,727,241	130,793	50.00
51.00	05100	RECOVERY ROOM	46,795	4,877,535	0.009594	1,142,942	10,965	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	458,072	8,819,510	0.051938	5,481	285	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,442	26,807,075	0.054144	3,018,664	163,443	54.00
54.02	03630	ULTRA SOUND	36,332	15,077,970	0.002410	1,014,838	2,446	54.02
56.00	05600	RADIOISOTOPE	153,304	4,689,241	0.032693	1,046,455	34,212	56.00
57.00	05700	CT SCAN	315,434	52,079,214	0.006057	7,854,087	47,572	57.00
59.00	05900	CARDIAC CATHETERIZATION	44,866	2,503,958	0.017918	1,209,678	21,675	59.00
60.00	06000	LABORATORY	349,929	66,886,621	0.005232	14,447,274	75,588	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	187,258	24,869,247	0.007530	7,930,192	59,714	65.00
66.00	06600	PHYSICAL THERAPY	95,393	2,438,224	0.039124	526,368	20,594	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,172	2,905,195	0.014516	547,778	7,952	67.00
68.00	06800	SPEECH PATHOLOGY	33,450	1,425,802	0.023460	384,224	9,014	68.00
69.00	06900	ELECTROCARDIOLOGY	280,207	17,674,002	0.015854	5,140,425	81,496	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,965	510,432	0.074378	152,937	11,375	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	391,344	18,551,046	0.021096	4,542,799	95,835	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,246	6,343,252	0.025578	1,232,139	31,516	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,988	38,166,280	0.007912	9,186,639	72,685	73.00
74.00	07400	RENAL DIALYSIS	57,276	4,025,451	0.014228	1,585,100	22,553	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	916,799	147,195,541	0.006228	14,686,593	91,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	221,691	8,105,572	0.027350	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	6,420,567	490,584,564		81,381,854	991,181	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/27/2018 2:18 pm
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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	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	200.00	
Cost Center Description		Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
		4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	43,907	0.00	11,204 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	4,505	0.00	1,551 31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	584	0.00	365 41.00	
43.00	04300	NURSERY	0	0	874	0.00	0 43.00	
200.00		Total (lines 30 through 199)	0	0	49,870		13,120 200.00	
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
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
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Cost Center Description	Title XVIII					Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00	
54.02 03630 ULTRASOUND	0	0	0	0	0	0	54.02	
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00	
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00	
62.30 06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	0	62.30	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00	
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98	
76.99 07699 LI THOTRI PSY	0	0	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.00 09000 CLINIC	0	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00	
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	36,633,396	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,877,535	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,819,510	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,807,075	0.000000	54.00
54.02	03630	ULTRA SOUND	0	0	0	15,077,970	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	4,689,241	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,079,214	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,503,958	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	66,886,621	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,869,247	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,438,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,905,195	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,425,802	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,674,002	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	510,432	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,551,046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,343,252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,166,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,025,451	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	147,195,541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,105,572	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	0	0	490,584,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
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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				
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	5,727,241	0	4,567,827	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	1,142,942	0	761,790	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,481	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	3,018,664	0	1,834,005	0	54.00	
54.02	03630	ULTRA SOUND	0.000000	1,014,838	0	514,497	0	54.02	
56.00	05600	RADIOISOTOPE	0.000000	1,046,455	0	353,670	0	56.00	
57.00	05700	CT SCAN	0.000000	7,854,087	0	4,605,055	0	57.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	1,209,678	0	408,007	0	59.00	
60.00	06000	LABORATORY	0.000000	14,447,274	0	2,682,619	0	60.00	
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	7,930,192	0	747,154	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	526,368	0	29,543	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	547,778	0	15,523	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	384,224	0	29,016	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,140,425	0	1,711,376	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	152,937	0	32,298	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4,542,799	0	929,846	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,232,139	0	683,870	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	9,186,639	0	1,570,940	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	1,585,100	0	48,386	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIpsy	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
91.00	09100	EMERGENCY	0.000000	14,686,593	0	7,750,701	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	1,688,655	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
200.00		Total (lines 50 through 199)		81,381,854	0	30,964,778	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/27/2018 2:18 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.226137	4,567,827	0	0	1,032,955	50.00
51.00	05100 RECOVERY ROOM	0.150482	761,790	0	0	114,636	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.481653	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230861	1,834,005	0	0	423,400	54.00
54.02	03630 ULTRA SOUND	0.089973	514,497	0	0	46,291	54.02
56.00	05600 RADIOISOTOPE	0.229215	353,670	0	0	81,066	56.00
57.00	05700 CT SCAN	0.043360	4,605,055	0	0	199,675	57.00
59.00	05900 CARDIAC CATHETERIZATION	0.274100	408,007	0	0	111,835	59.00
60.00	06000 LABORATORY	0.120964	2,682,619	0	0	324,500	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.125617	747,154	0	0	93,855	65.00
66.00	06600 PHYSICAL THERAPY	0.512051	29,543	0	0	15,128	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286278	15,523	0	0	4,444	67.00
68.00	06800 SPEECH PATHOLOGY	0.370115	29,016	0	0	10,739	68.00
69.00	06900 ELECTROCARDIOLOGY	0.089588	1,711,376	0	0	153,319	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.480046	32,298	0	0	15,505	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314535	929,846	0	0	292,469	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382843	683,870	0	0	261,815	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213325	1,570,940	0	0	335,121	73.00
74.00	07400 RENAL DIALYSIS	0.304312	48,386	0	0	14,724	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.118490	7,750,701	0	0	918,381	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.505292	1,688,655	0	0	853,264	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00	Subtotal (see instructions)		30,964,778	0	0	5,303,122	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		30,964,778	0	0	5,303,122	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/27/2018 2:18 pm
		Title XVIII	Hospital	PPS

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part II Date/Time Prepared: 11/27/2018 2:18 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	836,604	36,633,396	0.022837	32,242	736	50.00
51.00	05100	RECOVERY ROOM	46,795	4,877,535	0.009594	3,523	34	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	458,072	8,819,510	0.051938	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,442	26,807,075	0.054144	14,027	759	54.00
54.02	03630	ULTRA SOUND	36,332	15,077,970	0.002410	6,104	15	54.02
56.00	05600	RADIOISOTOPE	153,304	4,689,241	0.032693	6,681	218	56.00
57.00	05700	CT SCAN	315,434	52,079,214	0.006057	21,475	130	57.00
59.00	05900	CARDIAC CATHETERIZATION	44,866	2,503,958	0.017918	0	0	59.00
60.00	06000	LABORATORY	349,929	66,886,621	0.005232	91,334	478	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	187,258	24,869,247	0.007530	61,432	463	65.00
66.00	06600	PHYSICAL THERAPY	95,393	2,438,224	0.039124	191,876	7,507	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,172	2,905,195	0.014516	220,877	3,206	67.00
68.00	06800	SPEECH PATHOLOGY	33,450	1,425,802	0.023460	62,228	1,460	68.00
69.00	06900	ELECTROCARDIOLOGY	280,207	17,674,002	0.015854	19,928	316	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,965	510,432	0.074378	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	391,344	18,551,046	0.021096	41,903	884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,246	6,343,252	0.025578	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,988	38,166,280	0.007912	191,229	1,513	73.00
74.00	07400	RENAL DIALYSIS	57,276	4,025,451	0.014228	52,501	747	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	916,799	147,195,541	0.006228	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,105,572	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	6,198,876	490,584,564		1,017,360	18,466	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 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
54.02	03630 ULTRASOUND	0	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	36,633,396	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,877,535	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,819,510	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,807,075	0.000000	54.00
54.02	03630	ULTRA SOUND	0	0	0	15,077,970	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	4,689,241	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,079,214	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,503,958	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	66,886,621	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,869,247	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,438,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,905,195	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,425,802	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,674,002	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	510,432	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,551,046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,343,252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,166,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,025,451	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	147,195,541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,105,572	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	0	0	490,584,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	32,242	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	3,523	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	14,027	0	0	0	54.00
54.02	03630 ULTRA SOUND	0.000000	6,104	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0.000000	6,681	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	21,475	0	0	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	91,334	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	61,432	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	191,876	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	220,877	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	62,228	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	19,928	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	41,903	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	191,229	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	52,501	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
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
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00	Total (lines 50 through 199)		1,017,360	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part I Date/Time Prepared: 11/27/2018 2:18 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,961,684	0	1,961,684	43,907	44.68	30.00
31.00	INTENSIVE CARE UNIT	515,426		515,426	4,505	114.41	31.00
41.00	SUBPROVIDER - IRF	166,457	0	166,457	584	285.03	41.00
43.00	NURSERY	0		0	874	0.00	43.00
200.00	Total (lines 30 through 199)	2,643,567		2,643,567	49,870		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,741	122,468				
31.00	INTENSIVE CARE UNIT	353	40,387				
41.00	SUBPROVIDER - IRF	24	6,841				
43.00	NURSERY	691	0				
200.00	Total (lines 30 through 199)	3,809	169,696				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0133

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

Worksheet D
Part II
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	836,604	36,633,396	0.022837	0	0 50.00
51.00	05100	RECOVERY ROOM	46,795	4,877,535	0.009594	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	458,072	8,819,510	0.051938	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,442	26,807,075	0.054144	0	0 54.00
54.02	03630	ULTRA SOUND	36,332	15,077,970	0.002410	0	0 54.02
56.00	05600	RADIOISOTOPE	153,304	4,689,241	0.032693	0	0 56.00
57.00	05700	CT SCAN	315,434	52,079,214	0.006057	0	0 57.00
59.00	05900	CARDIAC CATHETERIZATION	44,866	2,503,958	0.017918	0	0 59.00
60.00	06000	LABORATORY	349,929	66,886,621	0.005232	0	0 60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	187,258	24,869,247	0.007530	0	0 65.00
66.00	06600	PHYSICAL THERAPY	95,393	2,438,224	0.039124	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	42,172	2,905,195	0.014516	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	33,450	1,425,802	0.023460	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	280,207	17,674,002	0.015854	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,965	510,432	0.074378	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	391,344	18,551,046	0.021096	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,246	6,343,252	0.025578	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,988	38,166,280	0.007912	0	0 73.00
74.00	07400	RENAL DIALYSIS	57,276	4,025,451	0.014228	0	0 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	0 90.00
91.00	09100	EMERGENCY	916,799	147,195,541	0.006228	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	221,691	8,105,572	0.027350	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0 94.00
200.00		Total (lines 50 through 199)	6,420,567	490,584,564		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/27/2018 2:18 pm
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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	
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 cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	43,907	0.00	2,741	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	4,505	0.00	353	31.00	
41.00	04100	SUBPROVIDER - IRF	0	0	584	0.00	24	41.00	
43.00	04300	NURSERY		0	874	0.00	691	43.00	
200.00		Total (lines 30 through 199)		0	49,870		3,809	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
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0133

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

Worksheet D
Part IV
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.02	03630	ULTRASOUND	0	0	0	0	0	54.02
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
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Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	36,633,396	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,877,535	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,819,510	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,807,075	0.000000	54.00
54.02	03630	ULTRA SOUND	0	0	0	15,077,970	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	4,689,241	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,079,214	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,503,958	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	66,886,621	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,869,247	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,438,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,905,195	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,425,802	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,674,002	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	510,432	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,551,046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,343,252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,166,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,025,451	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	147,195,541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,105,572	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	0	0	490,584,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
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Cost Center Description		Title XIX			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)	
ANCILLARY SERVICE COST CENTERS		9.00	10.00	11.00	12.00	13.00	
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
54.02	03630 ULTRA SOUND	0.000000	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
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
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
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
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
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
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/27/2018 2:18 pm
Title XIX			Subprovider - IRF	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	836,604	36,633,396	0.022837	0	50.00
51.00	05100	RECOVERY ROOM	46,795	4,877,535	0.009594	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	458,072	8,819,510	0.051938	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,451,442	26,807,075	0.054144	0	54.00
54.02	03630	ULTRA SOUND	36,332	15,077,970	0.002410	0	54.02
56.00	05600	RADIOISOTOPE	153,304	4,689,241	0.032693	0	56.00
57.00	05700	CT SCAN	315,434	52,079,214	0.006057	0	57.00
59.00	05900	CARDIAC CATHETERIZATION	44,866	2,503,958	0.017918	0	59.00
60.00	06000	LABORATORY	349,929	66,886,621	0.005232	0	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	187,258	24,869,247	0.007530	0	65.00
66.00	06600	PHYSICAL THERAPY	95,393	2,438,224	0.039124	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	42,172	2,905,195	0.014516	0	67.00
68.00	06800	SPEECH PATHOLOGY	33,450	1,425,802	0.023460	0	68.00
69.00	06900	ELECTROCARDIOLOGY	280,207	17,674,002	0.015854	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37,965	510,432	0.074378	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	391,344	18,551,046	0.021096	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	162,246	6,343,252	0.025578	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	301,988	38,166,280	0.007912	0	73.00
74.00	07400	RENAL DIALYSIS	57,276	4,025,451	0.014228	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0.000000	0	90.00
91.00	09100	EMERGENCY	916,799	147,195,541	0.006228	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	8,105,572	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	94.00
200.00		Total (lines 50 through 199)	6,198,876	490,584,564		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
	Title XIX	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
54.02	03630 ULTRASOUND	0	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	36,633,396	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	4,877,535	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,819,510	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,807,075	0.000000	54.00
54.02	03630	ULTRA SOUND	0	0	0	15,077,970	0.000000	54.02
56.00	05600	RADIOISOTOPE	0	0	0	4,689,241	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	52,079,214	0.000000	57.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	2,503,958	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	66,886,621	0.000000	60.00
62.30	06250	BLOOD CLOTTING FACTORS FOR HEMOPH.	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	24,869,247	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,438,224	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,905,195	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,425,802	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	17,674,002	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	510,432	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	18,551,046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,343,252	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	38,166,280	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,025,451	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	147,195,541	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	8,105,572	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	0	0	490,584,564		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/27/2018 2:18 pm
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	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
54.02	03630 ULTRA SOUND	0.000000	0	0	0	0	54.02
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
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
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	0	0	62.30
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
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
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
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 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)			43,907 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			43,907 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)			38,945 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			11,204 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)			36,241,300 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)			36,241,300 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)			36,241,300 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)			825.41 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			9,247,894 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			9,247,894 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 11/27/2018 2:18 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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	8,917,645	4,505	1,979.50	1,551	3,070,205		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)					13,099,121		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,417,220		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)					678,045		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					991,181		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,669,226		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,747,994		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)					4,962		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					825.41		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					4,095,684		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,961,684	36,241,300	0.054128	4,095,684	221,691	90.00
91.00	Nursing School cost	0	36,241,300	0.000000	4,095,684	0	91.00
92.00	Allied health cost	0	36,241,300	0.000000	4,095,684	0	92.00
93.00	All other Medical Education	0	36,241,300	0.000000	4,095,684	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 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)			584 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			584 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)			584 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)			365 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,137,573 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,137,573 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,137,573 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)			1,947.90 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			710,984 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)			710,984 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				289,085		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,000,069		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)				104,036		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				18,466		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				122,502		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				877,567		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
56.00	Target amount (line 54 x line 55)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 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	166,457	1,137,573	0.146326	0	0	90.00
91.00	Nursing School cost	0	1,137,573	0.000000	0	0	91.00
92.00	Allied health cost	0	1,137,573	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,137,573	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 pm
		Title XIX	Hospital	PPS
Cost Center Description		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		43,907	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		43,907	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)		38,945	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,741	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)		874	15.00
16.00	Nursery days (title V or XIX only)		691	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)		36,241,300	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)		36,241,300	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)		36,241,300	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)		825.41	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,262,449	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,262,449	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 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)	
Title XIX		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
42.00	NURSERY (title V & XIX only)	0	874	0.00	691	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	8,917,645	4,505	1,979.50	353	698,764	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,961,213	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)					162,855	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)					162,855	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,798,358	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)					4,962	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					825.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,095,684	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 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)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,961,684	36,241,300	0.054128	4,095,684	221,691	90.00
91.00	Nursing School cost	0	36,241,300	0.000000	4,095,684	0	91.00
92.00	Allied health cost	0	36,241,300	0.000000	4,095,684	0	92.00
93.00	All other Medical Education	0	36,241,300	0.000000	4,095,684	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 pm
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			584 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			584 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)			584 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)			24 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)			874 15.00
16.00	Nursery days (title V or XIX only)			691 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,137,573 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,137,573 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,137,573 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)			1,947.90 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			46,750 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)			46,750 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1
					Component CCN: 14-T133		Date/Time Prepared: 11/27/2018 2:18 pm
					Title XIX	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)						46,750	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						6,841	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						6,841	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						39,909	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0133 Component CCN: 14-T133		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/27/2018 2:18 pm	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	166,457	1,137,573	0.146326	0	0	90.00
91.00	Nursing School cost	0	1,137,573	0.000000	0	0	91.00
92.00	Allied health cost	0	1,137,573	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,137,573	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/27/2018 2:18 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		26,448,907		30.00
31.00	03100 INTENSIVE CARE UNIT		7,209,058		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	0.226137	5,727,241	1,295,141	50.00
51.00	05100 RECOVERY ROOM	0.150482	1,142,942	171,992	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.481653	5,481	2,640	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230861	3,018,664	696,892	54.00
54.02	03630 ULTRA SOUND	0.089973	1,014,838	91,308	54.02
56.00	05600 RADIOISOTOPE	0.229215	1,046,455	239,863	56.00
57.00	05700 CT SCAN	0.043360	7,854,087	340,553	57.00
59.00	05900 CARDIAC CATHETERIZATION	0.274100	1,209,678	331,573	59.00
60.00	06000 LABORATORY	0.120964	14,447,274	1,747,600	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.125617	7,930,192	996,167	65.00
66.00	06600 PHYSICAL THERAPY	0.512051	526,368	269,527	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286278	547,778	156,817	67.00
68.00	06800 SPEECH PATHOLOGY	0.370115	384,224	142,207	68.00
69.00	06900 ELECTROCARDIOLOGY	0.089588	5,140,425	460,520	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.480046	152,937	73,417	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314535	4,542,799	1,428,869	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382843	1,232,139	471,716	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213325	9,186,639	1,959,740	73.00
74.00	07400 RENAL DIALYSIS	0.304312	1,585,100	482,365	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.118490	14,686,593	1,740,214	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.505292	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		81,381,854	13,099,121	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)		81,381,854		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/27/2018 2:18 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		591,694		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.226137	32,242	7,291	50.00
51.00	05100 RECOVERY ROOM	0.150482	3,523	530	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.481653	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230861	14,027	3,238	54.00
54.02	03630 ULTRA SOUND	0.089973	6,104	549	54.02
56.00	05600 RADIOISOTOPE	0.229215	6,681	1,531	56.00
57.00	05700 CT SCAN	0.043360	21,475	931	57.00
59.00	05900 CARDIAC CATHETERIZATION	0.274100	0	0	59.00
60.00	06000 LABORATORY	0.120964	91,334	11,048	60.00
62.30	06250 BLOOD CLOTTING FACTORS FOR HEMOPH.	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.125617	61,432	7,717	65.00
66.00	06600 PHYSICAL THERAPY	0.512051	191,876	98,250	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.286278	220,877	63,232	67.00
68.00	06800 SPEECH PATHOLOGY	0.370115	62,228	23,032	68.00
69.00	06900 ELECTROCARDIOLOGY	0.089588	19,928	1,785	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.480046	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.314535	41,903	13,180	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.382843	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.213325	191,229	40,794	73.00
74.00	07400 RENAL DIALYSIS	0.304312	52,501	15,977	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.118490	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.505292	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,017,360	289,085	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)		1,017,360		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/27/2018 2: 18 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)		4,521,010	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		14,559,612	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)		113,703	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)		205.41	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		13.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)		45.92	31.00
32.00	Sum of lines 30 and 31		59.36	32.00
33.00	Allowable disproportionate share percentage (see instructions)		38.19	33.00
34.00	Disproportionate share adjustment (see instructions)		1,821,723	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/27/2018 2:18 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000406210	0.000344338	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	2,428,113	2,330,030	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	612,018	1,742,734	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,354,752		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	2,412		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	370	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	370	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	15.34		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	2,546		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.983012		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	447.81	447.81	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	162,874		46.00
47.00	Subtotal (see instructions)	23,533,674		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)		23,533,674	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,739,413	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		713	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)		25,273,800	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,273,800	61.00
62.00	Deductibles billed to program beneficiaries		2,034,841	62.00
63.00	Coinurance billed to program beneficiaries		128,291	63.00
64.00	Allowable bad debts (see instructions)		462,273	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		300,477	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		459,641	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		23,411,145	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		23,724	70.93
70.94	HRR adjustment amount (see instructions)		-237,587	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/27/2018 2:18 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)		23,197,282	71.00
71.01	Sequestration adjustment (see instructions)		463,946	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		22,389,910	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)		343,426	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
			Prior to 10/1	On/After 10/1
			1.00	2.00
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	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: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/27/2018 2: 18 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		5,303,122	2.00
3.00	OPPS payments		4,126,478	3.00
4.00	Outlier payment (see instructions)		3,077	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		4,129,555	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		852,318	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		3,277,237	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		3,277,237	30.00
31.00	Primary payer payments		342	31.00
32.00	Subtotal (line 30 minus line 31)		3,276,895	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)		80,396	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		52,257	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		78,883	36.00
37.00	Subtotal (see instructions)		3,329,152	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,329,152	40.00
40.01	Sequestration adjustment (see instructions)		66,583	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,505,428	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-242,859	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0133

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

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2018 2:18 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		22,389,910		3,505,428	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		22,389,910		3,505,428	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		343,426		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		242,859	6.02	
7.00	Total Medicare program liability (see instructions)		22,733,336		3,262,569	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

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

Worksheet E-1
Part I
Date/Time Prepared:
11/27/2018 2:18 pm

Title XVIII

Subprovider -
IRF

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		604,525		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		604,525		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,727		0	6.02
7.00	Total Medicare program liability (see instructions)		597,798		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0133 Component CCN: 14-T133	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part III Date/Time Prepared: 11/27/2018 2:18 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			540,772 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.1342 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			59,323 3.00
4.00	Outlier Payments			14,838 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)			1.600000 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)			614,933 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)			614,933 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			614,933 19.00
20.00	Deductibles			0 20.00
21.00	Subtotal (line 19 minus line 20)			614,933 21.00
22.00	Coinsurance			4,935 22.00
23.00	Subtotal (line 21 minus line 22)			609,998 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)			609,998 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)			609,998 32.00
32.01	Sequestration adjustment (see instructions)			12,200 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			604,525 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)			-6,727 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			14,838 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 14-0133 Period: From 07/01/2017 To 06/30/2018 Worksheet G
 Date/Time Prepared: 11/27/2018 2:18 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	14,010,000	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	48,528,000	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-13,504,000	0	0	0	6.00
7.00	Inventory	1,898,000	0	0	0	7.00
8.00	Prepaid expenses	5,530,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	1,994,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	58,456,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,700,000	0	0	0	12.00
13.00	Land improvements	707,000	0	0	0	13.00
14.00	Accumulated depreciation	-213,000	0	0	0	14.00
15.00	Buildings	97,257,000	0	0	0	15.00
16.00	Accumulated depreciation	-18,836,000	0	0	0	16.00
17.00	Leasehold improvements	245,000	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	31,216,000	0	0	0	23.00
24.00	Accumulated depreciation	-24,008,000	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	88,068,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	11,225,000	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	11,225,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	157,749,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	8,332,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,913,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	5,594,000	0	0	0	43.00
44.00	Other current liabilities	3,769,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	22,608,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	26,534,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,534,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	49,142,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	108,607,000	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	108,607,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	157,749,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0133

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

Worksheet G-1

Date/Time Prepared:
11/27/2018 2:18 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		113,083,214		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-4,476,214				2.00
3.00	Total (sum of line 1 and line 2)		108,607,000		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		108,607,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		108,607,000		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0133

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/27/2018 2:18 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	73,705,000		73,705,000	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	948,000		948,000	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	74,653,000		74,653,000	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,930,000		21,930,000	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	21,930,000		21,930,000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	96,583,000		96,583,000	17.00
18.00	Ancillary services	263,864,000	1	263,864,001	18.00
19.00	Outpatient services	0	239,426,000	239,426,000	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.20	OPT	0	0	0	24.20
24.30	OOT	0	0	0	24.30
24.40	OSP	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	360,447,000	239,426,001	599,873,001	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		129,974,468		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)		129,974,468		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0133

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

Worksheet G-3

Date/Time Prepared:
11/27/2018 2:18 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	599,873,001	1.00
2.00	Less contractual allowances and discounts on patients' accounts	479,444,000	2.00
3.00	Net patient revenues (line 1 minus line 2)	120,429,001	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	129,974,468	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,545,467	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,000	6.00
7.00	Income from investments	565,000	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	ALL OTHER OPERATING INCOME	5,374,000	24.00
25.00	Total other income (sum of lines 6-24)	5,940,000	25.00
26.00	Total (line 5 plus line 25)	-3,605,467	26.00
27.00	BAD DEBT	870,747	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	870,747	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,476,214	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0133	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/27/2018 2:18 pm
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,535,448	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		7,888	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)		119.08	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		13.44	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		45.92	8.00
9.00	Sum of lines 7 and 8		59.36	9.00
10.00	Allowable disproportionate share percentage (see instructions)		12.77	10.00
11.00	Disproportionate share adjustment (see instructions)		196,077	11.00
12.00	Total prospective capital payments (see instructions)		1,739,413	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