

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: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/16/2018 9:28 am
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<b>PART I - COST REPORT STATUS</b>			
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: 11/16/2018	Time: 9:28 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 MEMORIAL MEDICAL CENTER ( 14-0176 ) 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.

Encryption Information  
 ECR: Date: 11/16/2018 Time: 9:28 am  
 OERVwwwLVgj 8l0: MxBYmUVG0YU9gNO  
 ldbl kOYm0seh. pthTkJKdoJW2SKHHE  
 : Wpc1emb7COKPYCV  
 PI: Date: 11/16/2018 Time: 9:28 am  
 KOz6maLFh9Kei CeU6HmG. f71yKzWBO  
 2cGSVOOF1e. OmPDaEWS1vRvi uHn3BI  
 Hwi mOFODcpONNczx

(Signed) \_\_\_\_\_  
 Officer or Administrator of Provider(s)  
 \_\_\_\_\_  
 Title  
 \_\_\_\_\_  
 Date

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	Hospital	0	604,911	-70,321	0	1.00
2.00	Subprovider - IPF	0	0	0	0	2.00
3.00	Subprovider - IRF	0	0	0	0	3.00
5.00	Swing bed - SNF	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
200.00	Total	0	604,911	-70,321	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: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 9:27 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 3701 DOTY ROAD	PO Box:							1.00	
2.00	City: WOODSTOCK	State: IL		Zip Code: 60098-		County: MC HENRY			2.00	
		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	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	MEMORIAL MEDICAL CENTER	140176	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2017	06/30/2018		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	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		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.	843	545	0	0	1,610	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 9:27 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		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		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N		N	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	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	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)		N			60.00
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N		0.00	0.00
61.01	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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						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)						62.01	0.00
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>								
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
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000
		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		

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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	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0 76.00	

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 9:27 am		
		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			
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	610,848	9,637			0118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N				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
<b>Transplant Center Information</b>						
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
<b>All Providers</b>						
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		14H122		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/16/2018 9:27 am							
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: CENTEGRA HEALTH SYSTEM	Contractor's Name: NATIONAL GOVERNMENT SERVICES		Contractor's Number: 00131				141.00					
142.00	Street: 385 MILLENNIUM DR.	PO Box:						142.00					
143.00	City: CRYSTAL LAKE	State: IL		Zip Code: 60012-3761				143.00					
144.00 Are provider based physicians' costs included in Worksheet A?													
Y								144.00					
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.								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.								146.00					
N								146.00					
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								147.00					
N								147.00					
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								148.00					
N								148.00					
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								149.00					
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	N		N		N		N		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		N		161.00			
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													
		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)											166.00	
												0.00	
										1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act													
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.										N			
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			
168.01 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			
										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. 1, 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: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/16/2018 9:27 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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.				Y		15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/16/2018	Y	10/16/2018		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/16/2018 9:27 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		N		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
					Y/N
					Date
					1.00
					2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?		N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
					1.00
					2.00
<b>Cost Report Preparer Contact Information</b>					
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.	ANNA	BURACKER		41.00
42.00	Enter the employer/company name of the cost report preparer.	CENTEGRA HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(815)759-8037	ABURACKER@CENTEGRA.COM		43.00

		3.00	
<b>Cost Report Preparer Contact Information</b>			
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.	SENIOR REIMBURSEMENT ANALYST	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

VOLUNTARY CONTACT INFORMATION	Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part V Date/Time Prepared: 11/16/2018 9:27 am
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		1.00	
<b>Cost Report Preparer Contact Information</b>			
1.00	First Name	ANNA	1.00
2.00	Last Name	BURACKER	2.00
3.00	Title	SENIOR REIMBURSEMENT ANALYST	3.00
4.00	Employer	CENTEGRA HEALTH SYSTEM	4.00
5.00	Phone Number	(815)759-8037	5.00
6.00	E-mail Address	ABURACKER@CENTEGRA.COM	6.00
7.00	Department	FINANCE	7.00
8.00	Mailing Address 1	527 W. SOUTH STREET	8.00
9.00	Mailing Address 2		9.00
10.00	City	WOODSTOCK	10.00
11.00	State	IL	11.00
12.00	Zip	60098	12.00
<b>Officer or Administrator of Provider Contact Information</b>			
13.00	First Name	MICHAEL	13.00
14.00	Last Name	EESLEY	14.00
15.00	Title	CHIEF EXECUTIVE OFFICER	15.00
16.00	Employer	CENTEGRA HEALTH SYSTEM	16.00
17.00	Phone Number	(815)788-5800	17.00
18.00	E-mail Address	MEESLEY@CENTEGRA.COM	18.00
19.00	Department	ADMINISTRATION	19.00
20.00	Mailing Address 1	385 MELLENNIUM DRIVE	20.00
21.00	Mailing Address 2		21.00
22.00	City	CRYSTAL LAKE	22.00
23.00	State	IL	23.00
24.00	Zip	60012	24.00

HFS Supplemental Information		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part IX Date/Time Prepared: 11/16/2018 9:27 am
		Title V 1.00	Title XIX 2.00	
<b>TITLES V AND/OR XIX FOLLOWING MEDICARE</b>				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
		Inpatient 1.00	Outpatient 2.00	
<b>CRITICAL ACCESS HOSPITALS</b>				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V 1.00	Title XIX 2.00	
<b>RCE DISALLOWANCE</b>				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	Y	Y	6.00
<b>PASS THROUGH COST</b>				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	Y	Y	7.00
<b>RHC</b>				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
<b>FQHC</b>				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0176

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	32	15,400	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)		32	15,400	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	0	744	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						13.00
14.00 Total (see instructions)		32	16,144	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		32				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: 14-0176

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

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)	2,208	844	7,874			1.00
2.00 HMO and other (see instructions)	111	2,180				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,208	844	7,874			7.00
8.00 INTENSIVE CARE UNIT	113	12	249			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)	2,321	856	8,123	0.00	247.32	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	247.32	27.00
28.00 Observation Bed Days		2	76			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	0			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: 14-0176

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	356	90	1,429	1.00
2.00 HMO and other (see instructions)			19	392		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	356	90	1,429	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0176

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/16/2018 9:27 am

	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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	16,327,758	0	16,327,758	514,434.00	31.74
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,375,316	-33,644	1,341,672	39,651.00	33.84
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		512,372	0	512,372	8,793.00	58.27
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		63,115	0	63,115	448.00	140.88
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		11,080,109	0	11,080,109	216,046.00	51.29
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		10,584	0	10,584	115.00	92.03
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		0	4,167,447	4,167,447		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		0	353,323	353,323		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		636,324	0	636,324		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	-525,519	525,519	0	0.00	0.00
27.00	Administrative & General	5.00	1,179,719	-209,846	969,873	28,998.00	33.45

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0176

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/16/2018 9:27 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		705,570	0	705,570	32,198.00	21.91	28.00
29.00	Maintenance & Repairs	6.00	476,411	-15,251	461,160	15,776.00	29.23	29.00
30.00	Operation of Plant	7.00	956,136	-28,226	927,910	40,861.00	22.71	30.00
31.00	Laundry & Linen Service	8.00	41,876	-1,180	40,696	1,773.00	22.95	31.00
32.00	Housekeeping	9.00	699,730	-21,869	677,861	41,431.00	16.36	32.00
33.00	Housekeeping under contract (see instructions)		127,329	0	127,329	6,255.00	20.36	33.00
34.00	Dietary	10.00	452,441	-224,275	228,166	15,465.00	14.75	34.00
35.00	Dietary under contract (see instructions)		84,300	0	84,300	2,274.00	37.07	35.00
36.00	Cafeteria	11.00	0	208,350	208,350	9,723.00	21.43	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	443,221	-15,510	427,711	9,411.00	45.45	38.00
39.00	Central Services and Supply	14.00	58,957	-2,456	56,501	3,109.00	18.17	39.00
40.00	Pharmacy	15.00	1,312,002	-31,351	1,280,651	24,919.00	51.39	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0176

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/16/2018 9:27 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	17,244,957	0	17,244,957	555,161.00	31.06	1.00
2.00	Excluded area salaries (see instructions)	1,375,316	-33,644	1,341,672	39,651.00	33.84	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,869,641	33,644	15,903,285	515,510.00	30.85	3.00
4.00	Subtotal other wages & related costs (see inst.)	11,666,180	0	11,666,180	225,402.00	51.76	4.00
5.00	Subtotal wage-related costs (see inst.)	636,324	4,167,447	4,803,771	0.00	30.21	5.00
6.00	Total (sum of lines 3 thru 5)	28,172,145	4,201,091	32,373,236	740,912.00	43.69	6.00
7.00	Total overhead cost (see instructions)	6,012,173	183,905	6,196,078	232,193.00	26.69	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/16/2018 9:27 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	-307,603	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
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
5.00	401K/TSA Plan Administration fees	2,750	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
<b>HEALTH AND INSURANCE COST</b>			
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)	2,819,147	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	85,844	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	56,195	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)	157,098	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	389,824	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	1,205,832	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	62,734	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	48,949	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,520,770	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part V Date/Time Prepared: 11/16/2018 9:27 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		512,372	4,520,770
2.00	Hospital		512,372	4,520,770
3.00	Subprovider - IPF		0	0
4.00	Subprovider - IRF		0	0
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC			
15.00	Hospital-Based Health Clinic FQHC			
16.00	Hospital-Based-CMHC			
17.00	Renal Dialysis			
18.00	Other		0	0

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/16/2018 9:27 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.257953	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		3,702,326	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?		N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		15,474	5.00	
6.00	Medicaid charges		38,921,184	6.00	
7.00	Medicaid cost (line 1 times line 6)		10,039,836	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)		6,322,036	8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>					
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
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	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>					
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)		6,322,036	19.00	
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,223,028	443,587	3,666,615	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	831,390	443,587	1,274,977	21.00
22.00	Payments received from patients for amounts previously written off as charity care	46,158	122,864	169,022	22.00
23.00	Cost of charity care (line 21 minus line 22)	785,232	320,723	1,105,955	23.00
			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)		4,539,370	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		423,577	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		651,657	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		3,887,713	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		1,230,927	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,336,882	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,658,918	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet A Date/Time Prepared: 11/16/2018 9:27 am		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,365,524	14,365,524	-9,935,617	4,429,907	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	2,829,645	2,829,645	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-525,519	4,064,639	3,539,120	815,443	4,354,563	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,179,719	10,154,562	11,334,281	6,597,148	17,931,429	5.00
6.00	00600	MAINTENANCE & REPAIRS	476,411	840,647	1,317,058	-15,251	1,301,807	6.00
7.00	00700	OPERATION OF PLANT	956,136	1,182,024	2,138,160	-28,226	2,109,934	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	41,876	101,926	143,802	-1,180	142,622	8.00
9.00	00900	HOUSEKEEPING	699,730	443,306	1,143,036	-21,869	1,121,167	9.00
10.00	01000	DIETARY	452,441	534,428	986,869	-395,218	591,651	10.00
11.00	01100	CAFETERIA	0	0	0	379,293	379,293	11.00
13.00	01300	NURSING ADMINISTRATION	443,221	19,035	462,256	-18,123	444,133	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58,957	425,816	484,773	-2,955	481,818	14.00
15.00	01500	PHARMACY	1,312,002	1,446,884	2,758,886	-893,671	1,865,215	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,541,135	215,841	3,756,976	65,198	3,822,174	30.00
31.00	03100	INTENSIVE CARE UNIT	132,459	63,970	196,429	-753	195,676	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	253,071	1,424,601	1,677,672	-64,732	1,612,940	50.00
53.00	05300	ANESTHESIOLOGY	0	24,113	24,113	0	24,113	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,008,258	467,834	1,476,092	-38,312	1,437,780	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	81,552	76,578	158,130	-4,835	153,295	56.00
57.00	05700	CT SCAN	332,728	213,769	546,497	-10,594	535,903	57.00
58.00	05800	MRI	137,495	119,334	256,829	-4,053	252,776	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	143,759	878,974	1,022,733	-33,661	989,072	60.00
65.00	06500	RESPIRATORY THERAPY	305,443	60,967	366,410	-14,429	351,981	65.00
66.00	06600	PHYSICAL THERAPY	30,568	335	30,903	-1,030	29,873	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,758	29	9,787	-932	8,855	67.00
68.00	06800	SPEECH PATHOLOGY	12,393	78	12,471	-1,273	11,198	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	636,652	172,326	808,978	-26,817	782,161	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	507,691	507,691	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	863,786	863,786	73.00
76.00	03951	CARDIOLOGY	3,460	4,775	8,235	0	8,235	76.00
76.01	03950	WOUND CARE	617,688	1,217,044	1,834,732	-567,293	1,267,439	76.01
76.97	07697	CARDIAC REHABILITATION	149,529	10,401	159,930	-7,058	152,872	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	175,340	175,340	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	581,376	19,828	601,204	-25,608	575,596	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,880,144	650,260	2,530,404	-86,410	2,443,994	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,952,442	39,199,848	54,152,290	33,644	54,185,934	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.02	19002	CRISIS PROGRAM	1,375,316	34,248	1,409,564	-33,644	1,375,920	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	16,327,758	39,234,096	55,561,854	0	55,561,854	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0176

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

Worksheet A  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,420,521	2,009,386	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-6,495	2,823,150	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,354,563	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-9,455,261	8,476,168	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,301,807	6.00
7.00	00700	OPERATION OF PLANT	-218,872	1,891,062	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	142,622	8.00
9.00	00900	HOUSEKEEPING	-127,421	993,746	9.00
10.00	01000	DIETARY	0	591,651	10.00
11.00	01100	CAFETERIA	-163,589	215,704	11.00
13.00	01300	NURSING ADMINISTRATION	188,969	633,102	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	481,818	14.00
15.00	01500	PHARMACY	-290,725	1,574,490	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	177,639	177,639	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-63,273	3,758,901	30.00
31.00	03100	INTENSIVE CARE UNIT	-1,734	193,942	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	1,612,940	50.00
53.00	05300	ANESTHESIOLOGY	0	24,113	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-14,238	1,423,542	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	153,295	56.00
57.00	05700	CT SCAN	0	535,903	57.00
58.00	05800	MRI	0	252,776	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	989,072	60.00
65.00	06500	RESPIRATORY THERAPY	5,000	356,981	65.00
66.00	06600	PHYSICAL THERAPY	-115	29,758	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,855	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,198	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	-6,529	775,632	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	507,691	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	863,786	73.00
76.00	03951	CARDIOLOGY	0	8,235	76.00
76.01	03950	WOUND CARE	-64,403	1,203,036	76.01
76.97	07697	CARDIAC REHABILITATION	0	152,872	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	-17,616	157,724	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	575,596	90.03
90.04	09004	DIABETES CENTER	0	0	90.04
91.00	09100	EMERGENCY	-120,305	2,323,689	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-12,599,489	41,586,445	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.02	19002	CRISIS PRGRAM	0	1,375,920	190.02
191.00	19100	RESEARCH	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-12,599,489	42,962,365	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0176

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

Worksheet Non-CMS W  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
55.00	RADIOLOGY - THERAPEUTIC	05500		55.00
56.00	RADIOISOTOPE	05600		56.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
70.01	SLEEP LAB/NEUROLOGY	07001		70.01
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	CARDIOLOGY	03951		76.00
76.01	WOUND CARE	03950		76.01
76.97	CARDIAC REHABILITATION	07697		76.97
76.98	HYPERBARIC OXYGEN THERAPY	07698		76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	CLINIC	09000		90.00
90.01	WOMENS CENTER	09001		90.01
90.02	PSYCH SERVICES	09002		90.02
90.03	OP BEHAVIORAL HEALTH	09003		90.03
90.04	DIABETES CENTER	09004		90.04
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.02	CRISIS PROGRAM	19002		190.02
191.00	RESEARCH	19100		191.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - EQUIPMENT DEPRECIATION</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,731,180	1.00
	O		0	2,731,180	
<b>B - EQUIPMENT INTEREST</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	98,465	1.00
	O		0	98,465	
<b>C - NON-CAPITAL RELATED COSTS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	230,964	1.00
	O		0	230,964	
<b>D - NON-CAPITAL INSURANCE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	287,497	1.00
	O		0	287,497	
<b>E - WORKERS COMP INSURANCE</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	289,924	1.00
	O		0	289,924	
<b>F - PROVIDER TAX</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,759,515	1.00
	O		0	6,759,515	
<b>H - CHARGABLE DRUG COSTS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	863,786	1.00
	O		0	863,786	
<b>I - MED SUPPLIES &amp; IMPLANTS</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	507,691	1.00
2.00	PHARMACY	15.00	0	1,466	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
	O		0	509,157	
<b>J - CAFETERIA RECLASS</b>					
1.00	CAFETERIA	11.00	208,350	170,943	1.00
	O		208,350	170,943	
<b>K - ATO RECLASS</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	525,519	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	O		525,519	0	

Provider CCN: 14-0176

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

Worksheet A-6  
Date/Time Prepared:  
11/16/2018 9:27 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
N - CASE MANAGEMENT/SOCIAL SERVICES					
1.00	ADULTS & PEDIATRICS	30.00	178,909	8,776	1.00
2.00	INTENSIVE CARE UNIT	31.00	5,658	278	2.00
			184,567	9,054	
P - HYPERBARIC COSTS					
1.00	HYPERBARIC OXYGEN THERAPY	76.98	40,773	134,567	1.00
			40,773	134,567	
500.00	Grand Total: Increases		959,209	12,085,052	500.00

RECLASSIFICATIONS

Provider CCN: 14-0176

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

Worksheet A-6  
Date/Time Prepared:  
11/16/2018 9:27 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - EQUIPMENT DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,731,180	9		1.00
	O		0	2,731,180			
<b>B - EQUIPMENT INTEREST</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	98,465	11		1.00
	O		0	98,465			
<b>C - NON-CAPITAL RELATED COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	230,964	14		1.00
	O		0	230,964			
<b>D - NON-CAPITAL INSURANCE</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	287,497	12		1.00
	O		0	287,497			
<b>E - WORKERS COMP INSURANCE</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	289,924	12		1.00
	O		0	289,924			
<b>F - PROVIDER TAX</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,759,515	13		1.00
	O		0	6,759,515			
<b>H - CHARGABLE DRUG COSTS</b>							
1.00	PHARMACY	15.00	0	863,786	0		1.00
	O		0	863,786			
<b>I - MED SUPPLIES &amp; IMPLANTS</b>							
1.00	NURSING ADMINISTRATION	13.00	0	2,613	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	499	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	1,967	0		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	3,449	0		4.00
5.00	OPERATING ROOM	50.00	0	49,729	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,977	0		6.00
7.00	RADIOISOTOPE	56.00	0	17	0		7.00
8.00	CT SCAN	57.00	0	112	0		8.00
9.00	MRI	58.00	0	145	0		9.00
10.00	LABORATORY	60.00	0	30,741	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	4,759	0		11.00
12.00	SLEEP LAB/NEUROLOGY	70.01	0	8,133	0		12.00
13.00	WOUND CARE	76.01	0	370,841	0		13.00
14.00	CARDIAC REHABILITATION	76.97	0	72	0		14.00
15.00	EMERGENCY	91.00	0	30,103	0		15.00
	O		0	509,157			
<b>J - CAFETERIA RECLASS</b>							
1.00	DIETARY	10.00	208,350	170,943	0		1.00
	O		208,350	170,943			
<b>K - ATO RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	25,279	0	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	15,251	0	0		2.00
3.00	OPERATION OF PLANT	7.00	28,226	0	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	1,180	0	0		4.00
5.00	HOUSEKEEPING	9.00	21,869	0	0		5.00
6.00	DIETARY	10.00	15,925	0	0		6.00
7.00	NURSING ADMINISTRATION	13.00	15,510	0	0		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	2,456	0	0		8.00
9.00	PHARMACY	15.00	31,351	0	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	120,520	0	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	3,240	0	0		11.00
12.00	OPERATING ROOM	50.00	15,003	0	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	32,335	0	0		13.00
14.00	RADIOISOTOPE	56.00	4,818	0	0		14.00
15.00	CT SCAN	57.00	10,482	0	0		15.00
16.00	MRI	58.00	3,908	0	0		16.00
17.00	LABORATORY	60.00	2,920	0	0		17.00
18.00	RESPIRATORY THERAPY	65.00	9,670	0	0		18.00
19.00	PHYSICAL THERAPY	66.00	1,030	0	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	932	0	0		20.00
21.00	SPEECH PATHOLOGY	68.00	1,273	0	0		21.00
22.00	SLEEP LAB/NEUROLOGY	70.01	18,684	0	0		22.00
23.00	WOUND CARE	76.01	21,112	0	0		23.00
24.00	CARDIAC REHABILITATION	76.97	6,986	0	0		24.00
25.00	OP BEHAVIORAL HEALTH	90.03	25,608	0	0		25.00
26.00	EMERGENCY	91.00	56,307	0	0		26.00
27.00	CRISIS PRGRAM	190.02	33,644	0	0		27.00
	O		525,519	0			
<b>N - CASE MANAGEMENT/SOCIAL SERVICES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	184,567	9,054	0		1.00
2.00		0.00	0	0	0		2.00
	O		184,567	9,054			

RECLASSIFICATIONS

Provider CCN: 14-0176

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

Worksheet A-6

Date/Time Prepared:  
11/16/2018 9:27 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	P - HYPERBARIC COSTS						
1.00	WOUND CARE	76.01	40,773	134,567	0		1.00
	0		40,773	134,567			
500.00	Grand Total: Decreases		959,209	12,085,052			500.00

RECLASSIFICATIONS

Provider CCN: 14-0176

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
11/16/2018 9:27 am

Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
<b>A - EQUIPMENT DEPRECIATION</b>									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,731,180	CAP REL COSTS-BLDG & FIXT	1.00	0	2,731,180	1.00
	0		0	2,731,180	0		0	2,731,180	
<b>B - EQUIPMENT INTEREST</b>									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	98,465	CAP REL COSTS-BLDG & FIXT	1.00	0	98,465	1.00
	0		0	98,465	0		0	98,465	
<b>C - NON-CAPITAL RELATED COSTS</b>									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	230,964	ADMINISTRATIVE & GENERAL	5.00	0	230,964	1.00
	0		0	230,964	0		0	230,964	
<b>D - NON-CAPITAL INSURANCE</b>									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	287,497	CAP REL COSTS-BLDG & FIXT	1.00	0	287,497	1.00
	0		0	287,497	0		0	287,497	
<b>E - WORKERS COMP INSURANCE</b>									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	289,924	CAP REL COSTS-BLDG & FIXT	1.00	0	289,924	1.00
	0		0	289,924	0		0	289,924	
<b>F - PROVIDER TAX</b>									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,759,515	CAP REL COSTS-BLDG & FIXT	1.00	0	6,759,515	1.00
	0		0	6,759,515	0		0	6,759,515	
<b>H - CHARGABLE DRUG COSTS</b>									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	863,786	PHARMACY	15.00	0	863,786	1.00
	0		0	863,786	0		0	863,786	
<b>I - MED SUPPLIES &amp; IMPLANTS</b>									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	507,691	NURSING ADMINISTRATION	13.00	0	2,613	1.00
2.00	PHARMACY	15.00	0	1,466	CENTRAL SERVICES & SUPPLY	14.00	0	499	2.00
3.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	1,967	3.00
4.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	3,449	4.00
5.00		0.00	0	0	OPERATING ROOM	50.00	0	49,729	5.00
6.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	5,977	6.00
7.00		0.00	0	0	RADIOISOTOPE	56.00	0	17	7.00
8.00		0.00	0	0	CT SCAN	57.00	0	112	8.00
9.00		0.00	0	0	MRI	58.00	0	145	9.00
10.00		0.00	0	0	LABORATORY	60.00	0	30,741	10.00
11.00		0.00	0	0	RESPIRATORY THERAPY	65.00	0	4,759	11.00
12.00		0.00	0	0	SLEEP LAB/NEUROLOGY	70.01	0	8,133	12.00
13.00		0.00	0	0	WOUND CARE	76.01	0	370,841	13.00
14.00		0.00	0	0	CARDIAC REHABILITATION	76.97	0	72	14.00
15.00		0.00	0	0	EMERGENCY	91.00	0	30,103	15.00
	0		0	509,157	0		0	509,157	
<b>J - CAFETERIA RECLASS</b>									
1.00	CAFETERIA	11.00	208,350	170,943	DIETARY	10.00	208,350	170,943	1.00
	0		208,350	170,943	0		208,350	170,943	
<b>K - ATO RECLASS</b>									
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	525,519	0	ADMINISTRATIVE & GENERAL	5.00	25,279	0	1.00
2.00		0.00	0	0	MAINTENANCE & REPAIRS	6.00	15,251	0	2.00
3.00		0.00	0	0	OPERATION OF PLANT	7.00	28,226	0	3.00
4.00		0.00	0	0	LAUNDRY & LINEN SERVICE	8.00	1,180	0	4.00
5.00		0.00	0	0	HOUSEKEEPING	9.00	21,869	0	5.00
6.00		0.00	0	0	DIETARY	10.00	15,925	0	6.00
7.00		0.00	0	0	NURSING ADMINISTRATION	13.00	15,510	0	7.00
8.00		0.00	0	0	CENTRAL SERVICES & SUPPLY	14.00	2,456	0	8.00
9.00		0.00	0	0	PHARMACY	15.00	31,351	0	9.00
10.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	120,520	0	10.00
11.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	3,240	0	11.00
12.00		0.00	0	0	OPERATING ROOM	50.00	15,003	0	12.00
13.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	32,335	0	13.00
14.00		0.00	0	0	RADIOISOTOPE	56.00	4,818	0	14.00
15.00		0.00	0	0	CT SCAN	57.00	10,482	0	15.00
16.00		0.00	0	0	MRI	58.00	3,908	0	16.00
17.00		0.00	0	0	LABORATORY	60.00	2,920	0	17.00
18.00		0.00	0	0	RESPIRATORY THERAPY	65.00	9,670	0	18.00
19.00		0.00	0	0	PHYSICAL THERAPY	66.00	1,030	0	19.00

RECLASSIFICATIONS

Provider CCN: 14-0176

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

Worksheet A-6  
Non-CMS Worksheet  
Date/Time Prepared:  
11/16/2018 9:27 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
20.00		0.00	0	0	0 OCCUPATIONAL THERAPY	67.00	932	0	20.00
21.00		0.00	0	0	0 SPEECH PATHOLOGY	68.00	1,273	0	21.00
22.00		0.00	0	0	0 SLEEP LAB/NEUROLOGY	70.01	18,684	0	22.00
23.00		0.00	0	0	0 WOUND CARE	76.01	21,112	0	23.00
24.00		0.00	0	0	0 CARDIAC REHABILITATION	76.97	6,986	0	24.00
25.00		0.00	0	0	0 OP BEHAVIORAL HEALTH	90.03	25,608	0	25.00
26.00		0.00	0	0	0 EMERGENCY	91.00	56,307	0	26.00
27.00		0.00	0	0	0 CRISIS PROGRAM	190.02	33,644	0	27.00
			525,519	0			525,519	0	
N - CASE MANAGEMENT/SOCIAL SERVICES									
1.00	ADULTS & PEDIATRICS	30.00	178,909	8,776	ADMINISTRATIVE & GENERAL	5.00	184,567	9,054	1.00
2.00	INTENSIVE CARE UNIT	31.00	5,658	278		0.00	0	0	2.00
			184,567	9,054			184,567	9,054	
P - HYPERBARIC COSTS									
1.00	HYPERBARIC OXYGEN THERAPY	76.98	40,773	134,567	WOUND CARE	76.01	40,773	134,567	1.00
			40,773	134,567			40,773	134,567	
500.00	Grand Total : Increases		959,209	12,085,052	Grand Total : Decreases		959,209	12,085,052	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0176

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	219,885	0	0	0	0	1.00
2.00	Land Improvements	3,212,830	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	75,758,571	0	0	0	753,644	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	56,956,088	1,369,963	0	1,369,963	9,010,595	6.00
7.00	HIT designated Assets	9,336,651	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	145,484,025	1,369,963	0	1,369,963	9,764,239	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	145,484,025	1,369,963	0	1,369,963	9,764,239	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	219,885	0				1.00
2.00	Land Improvements	3,212,830	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	75,004,927	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	49,315,456	0				6.00
7.00	HIT designated Assets	9,336,651	0				7.00
8.00	Subtotal (sum of lines 1-7)	137,089,749	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	137,089,749	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0176

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/16/2018 9:27 am

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	14,365,524	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	14,365,524	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	14,365,524				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	14,365,524				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0176

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	78,437,642	0	78,437,642	0.572163	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	58,652,107	0	58,652,107	0.427837	0	2.00
3.00	Total (sum of lines 1-2)	137,089,749	0	137,089,749	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	11,634,344	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	2,724,685	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	14,359,029	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	-2,518,986	-577,421	-6,759,515	230,964	2,009,386	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	98,465	0	0	0	2,823,150	2.00
3.00	Total (sum of lines 1-2)	-2,420,521	-577,421	-6,759,515	230,964	4,832,536	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0176

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

Worksheet A-8

Date/Time Prepared:  
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center		Line #	
			1.00	2.00	3.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,899,109	CAP REL COSTS-BLDG & FIXT		1.00	11 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)	A	-178,255	OPERATION OF PLANT		7.00	0 8.00
9.00 Parking lot (chapter 21)		0			0.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-301,840				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	-2,138,574				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-155,137	CAFETERIA		11.00	0 14.00
15.00 Rental of quarters to employee and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-1,762	MEDICAL RECORDS & LIBRARY		16.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		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	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 EDUCATION INCOME	B	-960	NURSING ADMINISTRATION		13.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0176

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

Worksheet A-8

Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
34.00 OTHER INCOME	B	7,500	ADULTS & PEDIATRICS	30.00	0	34.00
35.00 MISCELLANEOUS INCOME	B	-98,469	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00 PHARMACY RETAIL INCOME	B	-290,725	PHARMACY	15.00	0	36.00
37.00 OPERATION PLANT	B	-37,630	OPERATION OF PLANT	7.00	0	37.00
38.00 HOUSEKEEPING OTHER REVENUE	B	-127,421	HOUSEKEEPING	9.00	0	38.00
39.00 2012 & 2014 INTEREST EXPENSE	A	-521,450	CAP REL COSTS-BLDG & FIXT	1.00	11	39.00
40.00 2012 & 2014 INTEREST INCOME	B	38	CAP REL COSTS-BLDG & FIXT	1.00	11	40.00
41.00 PATIENT TELEPHONE CRC OFFSET	A	-6,495	CAP REL COSTS-MVBLE EQUIP	2.00	9	41.00
42.00 MEALS ON WHEELS	B	-8,452	CAFETERIA	11.00	0	42.00
43.00 POM RELATED RENTAL	A	-2,987	OPERATION OF PLANT	7.00	0	43.00
44.00 WOUND CARE RENTAL	A	-60,630	WOUND CARE	76.01	0	44.00
45.00 HBOT RENTAL	A	-17,616	HYPERBARIC OXYGEN THERAPY	76.98	0	45.00
45.01 IDPA PROVIDER TAX	A	-6,759,515	ADMINISTRATIVE & GENERAL	5.00	0	45.01
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-12,599,489				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: 14-0176  
 Period: From 07/01/2017 To 06/30/2018  
 Worksheet A-8-1  
 Date/Time Prepared: 11/16/2018 9:27 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CENTEGRA ALLOCATION	7,453,040	10,045,262 1.00
2.00	13.00	NURSING ADMINISTRATION	CENTEGRA ALLOCATION	189,929	0 2.00
3.00	16.00	MEDICAL RECORDS & LIBRARY	CENTEGRA ALLOCATION	179,401	0 3.00
4.00	91.00	EMERGENCY	CENTEGRA ALLOCATION	84,318	0 4.00
5.00	0		0	7,906,688	10,045,262 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	B		0.00	CENTEGRA HEALTH	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
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0176

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

Worksheet A-8-1

Date/Time Prepared:  
11/16/2018 9:27 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-2,592,222	0		1.00
2.00	189,929	0		2.00
3.00	179,401	0		3.00
4.00	84,318	0		4.00
5.00	-2,138,574			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>			

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0176

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

Worksheet A-8-2

Date/Time Prepared:  
11/16/2018 9:27 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	31.00	INTENSIVE CARE UNIT	2,778	0	2,778	197,500	11	1.00
2.00	30.00	ADULTS & PEDIATRICS	70,773	70,773	0	0	0	2.00
3.00	53.00	DR. AA	1,050	0	1,050	246,400	47	3.00
4.00	53.00	DR. AB	1,050	0	1,050	246,400	9	4.00
5.00	91.00	EMERGENCY	202,994	202,994	0	0	0	5.00
6.00	91.00	EMERGENCY	4,171	0	4,171	211,500	25	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	4,463	4,463	0	0	0	7.00
8.00	54.00	DR. AC	28,599	0	28,599	271,900	144	8.00
9.00	54.00	DR. AD	2,400	0	2,400	271,900	101	9.00
10.00	76.97	CARDIAC REHABILITATION	2,100	0	2,100	211,500	22	10.00
11.00	65.00	RESPIRATORY THERAPY	-5,000	-5,000	0	0	0	11.00
12.00	76.01	WOUND CARE	8,450	0	8,450	211,500	46	12.00
13.00	70.01	SLEEP LAB/NEUROLOGY	10,800	-1,500	12,300	211,500	42	13.00
14.00	66.00	PHYSICAL THERAPY	217	0	217	211,500	1	14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	2,200	2,200	0	0	0	15.00
16.00	5.00	DR. AE	1,375	0	1,375	211,500	5	16.00
17.00	5.00	DR. AF	734	0	734	211,500	8	17.00
18.00	5.00	DR. AG	2,700	0	2,700	211,500	7	18.00
19.00	5.00	DR. AH	5,775	0	5,775	211,500	95	19.00
200.00			347,629	273,930	73,699		563	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	31.00	INTENSIVE CARE UNIT	1,044	52	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	DR. AA	5,568	278	0	0	0	3.00
4.00	53.00	DR. AB	1,066	53	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	2,542	127	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	7.00
8.00	54.00	DR. AC	18,824	941	0	0	0	8.00
9.00	54.00	DR. AD	13,203	660	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	2,237	112	0	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	11.00
12.00	76.01	WOUND CARE	4,677	234	0	0	0	12.00
13.00	70.01	SLEEP LAB/NEUROLOGY	4,271	214	0	0	0	13.00
14.00	66.00	PHYSICAL THERAPY	102	5	0	0	0	14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	15.00
16.00	5.00	DR. AE	508	25	0	0	0	16.00
17.00	5.00	DR. AF	813	41	0	0	0	17.00
18.00	5.00	DR. AG	712	36	0	0	0	18.00
19.00	5.00	DR. AH	9,660	483	0	0	0	19.00
200.00			65,227	3,261	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	31.00	INTENSIVE CARE UNIT	0	1,044	1,734	1,734	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	70,773	2.00
3.00	53.00	DR. AA	0	5,568	0	0	3.00
4.00	53.00	DR. AB	0	1,066	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	202,994	5.00
6.00	91.00	EMERGENCY	0	2,542	1,629	1,629	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	4,463	7.00
8.00	54.00	DR. AC	0	18,824	9,775	9,775	8.00
9.00	54.00	DR. AD	0	13,203	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	2,237	0	0	10.00
11.00	65.00	RESPIRATORY THERAPY	0	0	0	-5,000	11.00
12.00	76.01	WOUND CARE	0	4,677	3,773	3,773	12.00
13.00	70.01	SLEEP LAB/NEUROLOGY	0	4,271	8,029	6,529	13.00
14.00	66.00	PHYSICAL THERAPY	0	102	115	115	14.00
15.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	2,200	15.00
16.00	5.00	DR. AE	0	508	867	867	16.00
17.00	5.00	DR. AF	0	813	0	0	17.00
18.00	5.00	DR. AG	0	712	1,988	1,988	18.00
19.00	5.00	DR. AH	0	9,660	0	0	19.00
200.00			0	65,227	27,910	301,840	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0176

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,009,386	2,009,386			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	2,823,150		2,823,150		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	4,354,563	0	0	4,354,563	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,476,168	1,218,929	1,712,576	258,662	11,666,335
6.00 00600	MAINTENANCE & REPAIRS	1,301,807	258,049	362,555	122,990	2,045,401
7.00 00700	OPERATION OF PLANT	1,891,062	7,935	11,149	247,471	2,157,617
8.00 00800	LAUNDRY & LINEN SERVICE	142,622	4,487	6,304	10,854	164,267
9.00 00900	HOUSEKEEPING	993,746	20,021	28,129	180,783	1,222,679
10.00 01000	DIETARY	591,651	38,253	53,745	60,851	744,500
11.00 01100	CAFETERIA	215,704	0	0	55,566	271,270
13.00 01300	NURSING ADMINISTRATION	633,102	2,669	3,749	114,069	753,589
14.00 01400	CENTRAL SERVICES & SUPPLY	481,818	30,466	42,804	15,069	570,157
15.00 01500	PHARMACY	1,574,490	9,854	13,845	341,546	1,939,735
16.00 01600	MEDICAL RECORDS & LIBRARY	177,639	28,771	40,423	0	246,833
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	3,758,901	111,088	156,076	959,980	4,986,045
31.00 03100	INTENSIVE CARE UNIT	193,942	5,048	7,092	35,971	242,053
40.00 04000	SUBPROVIDER - I/PF	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	1,612,940	19,933	28,005	63,492	1,724,370
53.00 05300	ANESTHESIOLOGY	24,113	0	0	0	24,113
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,423,542	49,944	70,170	260,276	1,803,932
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0
56.00 05600	RADIOISOTOPE	153,295	3,171	4,455	20,465	181,386
57.00 05700	CT SCAN	535,903	8,207	11,530	85,942	641,582
58.00 05800	MRI	252,776	10,899	15,313	35,627	314,615
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	989,072	34,847	48,959	37,561	1,110,439
65.00 06500	RESPIRATORY THERAPY	356,981	0	0	78,882	435,863
66.00 06600	PHYSICAL THERAPY	29,758	5,467	7,681	7,878	50,784
67.00 06700	OCCUPATIONAL THERAPY	8,855	0	0	2,354	11,209
68.00 06800	SPEECH PATHOLOGY	11,198	0	0	2,966	14,164
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
70.01 07001	SLEEP LAB/NEUROLOGY	775,632	2,102	2,953	164,810	945,497
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	507,691	0	0	0	507,691
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	863,786	0	0	0	863,786
76.00 03951	CARDIOLOGY	8,235	10,096	14,185	923	33,439
76.01 03950	WOUND CARE	1,203,036	0	0	148,231	1,351,267
76.97 07697	CARDIAC REHABILITATION	152,872	2,220	3,119	38,016	196,227
76.98 07698	HYPERBARIC OXYGEN THERAPY	157,724	0	0	10,874	168,598
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	WOMENS CENTER	0	0	0	0	0
90.02 09002	PSYCH SERVICES	0	0	0	0	0
90.03 09003	OP BEHAVIORAL HEALTH	575,596	41,820	58,756	148,222	824,394
90.04 09004	DIABETES CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	2,323,689	62,171	87,350	486,412	2,959,622
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	41,586,445	1,986,447	2,790,923	3,996,743	41,173,459
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,669	3,749	0	6,418
190.02 19002	CRISIS PROGRAM	1,375,920	7,363	10,344	357,820	1,751,447
191.00 19100	RESEARCH	0	0	0	0	0
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	12,907	18,134	0	31,041
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	42,962,365	2,009,386	2,823,150	4,354,563	42,962,365

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part I Date/Time Prepared: 11/16/2018 9:27 am	
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,666,335					5.00
6.00	00600	MAINTENANCE & REPAIRS	762,472	2,807,873				6.00
7.00	00700	OPERATION OF PLANT	804,304	41,850	3,003,771			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	61,234	23,665	25,699	274,865		8.00
9.00	00900	HOUSEKEEPING	455,783	105,590	114,666	0	1,898,718	9.00
10.00	01000	DIETARY	277,530	201,746	219,086	0	145,276	10.00
11.00	01100	CAFETERIA	101,122	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	280,918	14,075	15,284	0	10,135	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	212,540	160,674	174,485	0	115,700	14.00
15.00	01500	PHARMACY	723,083	51,970	56,437	0	37,423	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	92,013	151,737	164,780	0	109,265	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,858,659	585,869	636,226	64,674	421,881	30.00
31.00	03100	INTENSIVE CARE UNIT	90,231	26,623	28,912	0	19,171	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	642,800	105,123	114,159	0	75,698	50.00
53.00	05300	ANESTHESIOLOGY	8,989	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	672,459	263,400	286,040	64,674	189,672	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	67,616	16,721	18,159	0	12,041	56.00
57.00	05700	CT SCAN	239,165	43,282	47,003	0	31,167	57.00
58.00	05800	MRI	117,280	57,481	62,422	0	41,392	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	413,943	183,779	199,575	0	132,338	60.00
65.00	06500	RESPIRATORY THERAPY	162,478	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	18,931	28,834	31,313	0	20,763	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,178	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	5,280	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	352,457	11,085	12,038	0	7,982	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	189,254	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	321,997	0	0	0	0	73.00
76.00	03951	CARDIOLOGY	12,465	53,247	57,823	0	38,343	76.00
76.01	03950	WOUND CARE	503,717	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	73,148	11,708	12,714	0	8,431	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	62,849	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	307,313	220,553	239,510	0	158,819	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	1,103,270	327,887	356,070	145,517	236,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,999,478	2,686,899	2,872,401	274,865	1,811,606	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,392	14,075	15,284	0	10,135	190.00
190.02	19002	CRISIS PROGRAM	652,894	38,830	42,167	0	27,961	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	11,571	68,069	73,919	0	49,016	192.00
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)	11,666,335	2,807,873	3,003,771	274,865	1,898,718	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0176

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	1,588,138					10.00
11.00	01100		372,392				11.00
13.00	01300		9,714	1,083,715			13.00
14.00	01400		3,202		1,236,758		14.00
15.00	01500		25,746			2,834,394	15.00
16.00	01600						16.00
17.00	01700						17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	1,539,465	108,078	470,518			30.00
31.00	03100	48,673	4,427	19,274			31.00
40.00	04000						40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000		6,469	28,162			50.00
53.00	05300						53.00
54.00	05400		26,283				54.00
55.00	05500						55.00
56.00	05600		1,655				56.00
57.00	05700		8,059				57.00
58.00	05800		2,901				58.00
59.00	05900						59.00
60.00	06000		4,083				60.00
65.00	06500		9,005	39,202			65.00
66.00	06600		344				66.00
67.00	06700		236				67.00
68.00	06800		279				68.00
70.00	07000						70.00
70.01	07001		19,686	85,702			70.01
71.00	07100				1,236,758		71.00
72.00	07200						72.00
73.00	07300					2,834,394	73.00
76.00	03951		86	374			76.00
76.01	03950		19,019	82,801			76.01
76.97	07697		3,911	17,028			76.97
76.98	07698		1,354	5,894			76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000						90.00
90.01	09001						90.01
90.02	09002						90.02
90.03	09003		18,246	79,433			90.03
90.04	09004						90.04
91.00	09100		58,648	255,327			91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		1,588,138	331,431	1,083,715	1,236,758	2,834,394	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000						190.00
190.02	19002		40,961				190.02
191.00	19100						191.00
192.00	19200						192.00
200.00							200.00
201.00							201.00
202.00		1,588,138	372,392	1,083,715	1,236,758	2,834,394	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0176

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
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	764,628				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	98,784	0	10,770,199	0	10,770,199
31.00	03100	INTENSIVE CARE UNIT	3,388	0	482,752	0	482,752
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	12,562	0	2,709,343	0	2,709,343
53.00	05300	ANESTHESIOLOGY	983	0	34,085	0	34,085
54.00	05400	RADIOLOGY-DIAGNOSTIC	68,941	0	3,375,401	0	3,375,401
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	3,689	0	301,267	0	301,267
57.00	05700	CT SCAN	102,162	0	1,112,420	0	1,112,420
58.00	05800	MRI	52,695	0	648,786	0	648,786
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	59,189	0	2,103,346	0	2,103,346
65.00	06500	RESPIRATORY THERAPY	2,393	0	648,941	0	648,941
66.00	06600	PHYSICAL THERAPY	389	0	151,358	0	151,358
67.00	06700	OCCUPATIONAL THERAPY	189	0	15,812	0	15,812
68.00	06800	SPEECH PATHOLOGY	70	0	19,793	0	19,793
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	44,418	0	1,478,865	0	1,478,865
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,779	0	1,938,482	0	1,938,482
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,345	0	4,043,522	0	4,043,522
76.00	03951	CARDIOLOGY	222	0	195,999	0	195,999
76.01	03950	WOUND CARE	51,857	0	2,008,661	0	2,008,661
76.97	07697	CARDIAC REHABILITATION	2,954	0	326,121	0	326,121
76.98	07698	HYPERBARIC OXYGEN THERAPY	10,089	0	248,784	0	248,784
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	35,999	0	1,884,267	0	1,884,267
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	185,531	0	5,627,981	0	5,627,981
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	764,628	0	40,126,185	0	40,126,185
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	48,304	0	48,304
190.02	19002	CRISIS PROGRAM	0	0	2,554,260	0	2,554,260
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	233,616	0	233,616
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	764,628	0	42,962,365	0	42,962,365

Provider CCN: 14-0176

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

Worksheet Non-CMS W  
 Date/Time Prepared:  
 11/16/2018 9:27 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	2	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	3	MEALS SERVED	10.00
11.00	CAFETERIA	4	FTE	11.00
13.00	NURSING ADMINISTRATION	13	NURSING HOURS/FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS	14.00
15.00	PHARMACY	15	COSTED REQUIS	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	16	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/16/2018 9:27 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
		0	1.00		
<b>GENERAL SERVICE COST CENTERS</b>					
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	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	188,600	1,218,929	1,712,576	5.00
6.00 00600	MAINTENANCE & REPAIRS	19,875	258,049	362,555	6.00
7.00 00700	OPERATION OF PLANT	4,344	7,935	11,149	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	4,487	6,304	8.00
9.00 00900	HOUSEKEEPING	0	20,021	28,129	9.00
10.00 01000	DIETARY	5,175	38,253	53,745	10.00
11.00 01100	CAFETERIA	0	0	0	11.00
13.00 01300	NURSING ADMINISTRATION	18	2,669	3,749	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	248,216	30,466	42,804	14.00
15.00 01500	PHARMACY	451,244	9,854	13,845	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	28,771	40,423	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS	0	111,088	156,076	30.00
31.00 03100	INTENSIVE CARE UNIT	0	5,048	7,092	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM	6,089	19,933	28,005	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	49,944	70,170	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	55.00
56.00 05600	RADIOISOTOPE	0	3,171	4,455	56.00
57.00 05700	CT SCAN	481	8,207	11,530	57.00
58.00 05800	MRI	0	10,899	15,313	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000	LABORATORY	0	34,847	48,959	60.00
65.00 06500	RESPIRATORY THERAPY	1,136	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	5,467	7,681	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	75,381	2,102	2,953	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
76.00 03951	CARDIOLOGY	0	10,096	14,185	76.00
76.01 03950	WOUND CARE	117,838	0	0	76.01
76.97 07697	CARDIAC REHABILITATION	0	2,220	3,119	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	33,245	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC	0	0	0	90.00
90.01 09001	WOMENS CENTER	0	0	0	90.01
90.02 09002	PSYCH SERVICES	0	0	0	90.02
90.03 09003	OP BEHAVIORAL HEALTH	50	41,820	58,756	90.03
90.04 09004	DIABETES CENTER	0	0	0	90.04
91.00 09100	EMERGENCY	24,142	62,171	87,350	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,175,834	1,986,447	2,790,923	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,669	3,749	190.00
190.02 19002	CRISIS PRGRAM	0	7,363	10,344	190.02
191.00 19100	RESEARCH	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	12,907	18,134	192.00
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers		0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,175,834	2,009,386	2,823,150	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/16/2018 9:27 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	3,120,105			5.00		
6.00	00600	MAINTENANCE & REPAIRS	203,920	844,399		6.00		
7.00	00700	OPERATION OF PLANT	215,108	12,585	251,121	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	16,377	7,117	2,149	36,434	8.00	
9.00	00900	HOUSEKEEPING	121,897	31,754	9,586	0	211,387	9.00
10.00	01000	DIETARY	74,224	60,670	18,316	0	16,174	10.00
11.00	01100	CAFETERIA	27,045	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	75,131	4,233	1,278	0	1,128	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,843	48,319	14,587	0	12,881	14.00
15.00	01500	PHARMACY	193,386	15,629	4,718	0	4,166	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,609	45,631	13,776	0	12,165	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	497,077	176,184	53,189	8,573	46,968	30.00
31.00	03100	INTENSIVE CARE UNIT	24,132	8,006	2,417	0	2,134	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	171,915	31,613	9,544	0	8,428	50.00
53.00	05300	ANESTHESIOLOGY	2,404	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	179,847	79,211	23,913	8,573	21,116	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	18,084	5,029	1,518	0	1,341	56.00
57.00	05700	CT SCAN	63,964	13,016	3,930	0	3,470	57.00
58.00	05800	MRI	31,366	17,286	5,219	0	4,608	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	110,707	55,267	16,685	0	14,733	60.00
65.00	06500	RESPIRATORY THERAPY	43,454	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,063	8,671	2,618	0	2,312	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,118	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,412	0	0	0	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	94,263	3,334	1,006	0	889	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,615	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	86,117	0	0	0	0	73.00
76.00	03951	CARDIOLOGY	3,334	16,013	4,834	0	4,269	76.00
76.01	03950	WOUND CARE	134,717	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	19,563	3,521	1,063	0	939	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	16,809	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	82,190	66,326	20,024	0	17,682	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	295,065	98,604	29,768	19,288	26,286	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,941,756	808,019	240,138	36,434	201,689	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	640	4,233	1,278	0	1,128	190.00
190.02	19002	CRISIS PROGRAM	174,614	11,677	3,525	0	3,113	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,095	20,470	6,180	0	5,457	192.00
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)	3,120,105	844,399	251,121	36,434	211,387	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/16/2018 9:27 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	266,557					10.00
11.00	01100	0	27,045				11.00
13.00	01300	0	705	88,911			13.00
14.00	01400	0	233	0	454,349		14.00
15.00	01500	0	1,870	0	0	694,712	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	258,388	7,849	38,603	0	0	30.00
31.00	03100	8,169	322	1,581	0	0	31.00
40.00	04000	0	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	470	2,310	0	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	1,909	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	0	120	0	0	0	56.00
57.00	05700	0	585	0	0	0	57.00
58.00	05800	0	211	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	297	0	0	0	60.00
65.00	06500	0	654	3,216	0	0	65.00
66.00	06600	0	25	0	0	0	66.00
67.00	06700	0	17	0	0	0	67.00
68.00	06800	0	20	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	0	1,430	7,031	0	0	70.01
71.00	07100	0	0	0	454,349	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	694,712	73.00
76.00	03951	0	6	31	0	0	76.00
76.01	03950	0	1,381	6,793	0	0	76.01
76.97	07697	0	284	1,397	0	0	76.97
76.98	07698	0	98	484	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	1,325	6,517	0	0	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	0	4,259	20,948	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		266,557	24,070	88,911	454,349	694,712	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.02	19002	0	2,975	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		266,557	27,045	88,911	454,349	694,712	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/16/2018 9:27 am		
Cost Center	Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		16.00	17.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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
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	165,375				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	21,365	0	1,375,360	0	30.00
31.00	03100	INTENSIVE CARE UNIT	733	0	59,634	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	2,717	0	281,024	0	50.00
53.00	05300	ANESTHESIOLOGY	213	0	2,617	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,910	0	449,593	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	798	0	34,516	0	56.00
57.00	05700	CT SCAN	22,095	0	127,278	0	57.00
58.00	05800	MRI	11,397	0	96,299	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	12,801	0	294,296	0	60.00
65.00	06500	RESPIRATORY THERAPY	518	0	48,978	0	65.00
66.00	06600	PHYSICAL THERAPY	84	0	31,921	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	41	0	1,176	0	67.00
68.00	06800	SPEECH PATHOLOGY	15	0	1,447	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	9,607	0	197,996	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,033	0	505,997	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,049	0	785,878	0	73.00
76.00	03951	CARDIOLOGY	48	0	52,816	0	76.00
76.01	03950	WOUND CARE	11,216	0	271,945	0	76.01
76.97	07697	CARDIAC REHABILITATION	639	0	32,745	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,182	0	52,818	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	7,786	0	302,476	0	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	90.04
91.00	09100	EMERGENCY	40,128	0	708,009	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	165,375	0	5,714,819	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	13,697	0	190.00
190.02	19002	CRISIS PROGRAM	0	0	213,611	0	190.02
191.00	19100	RESEARCH	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	66,243	0	192.00
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	165,375	0	6,008,370	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

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

Worksheet B-1  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	340,331				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		340,331			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	16,327,758		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	206,451	206,451	969,873	-11,666,335	5.00
6.00 00600	MAINTENANCE & REPAIRS	43,706	43,706	461,160	0	6.00
7.00 00700	OPERATION OF PLANT	1,344	1,344	927,910	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	760	760	40,696	0	8.00
9.00 00900	HOUSEKEEPING	3,391	3,391	677,861	0	9.00
10.00 01000	DIETARY	6,479	6,479	228,166	0	10.00
11.00 01100	CAFETERIA	0	0	208,350	0	11.00
13.00 01300	NURSING ADMINISTRATION	452	452	427,711	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	5,160	5,160	56,501	0	14.00
15.00 01500	PHARMACY	1,669	1,669	1,280,651	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,873	4,873	0	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	18,815	18,815	3,599,524	0	30.00
31.00 03100	INTENSIVE CARE UNIT	855	855	134,877	0	31.00
40.00 04000	SUBPROVIDER - IPF	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	3,376	3,376	238,068	0	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,459	8,459	975,923	0	54.00
55.00 05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	55.00
56.00 05600	RADIOISOTOPE	537	537	76,734	0	56.00
57.00 05700	CT SCAN	1,390	1,390	322,246	0	57.00
58.00 05800	MRI	1,846	1,846	133,587	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	5,902	5,902	140,839	0	60.00
65.00 06500	RESPIRATORY THERAPY	0	0	295,773	0	65.00
66.00 06600	PHYSICAL THERAPY	926	926	29,538	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	8,826	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	11,120	0	68.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
70.01 07001	SLEEP LAB/NEUROLOGY	356	356	617,968	0	70.01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00 03951	CARDIOLOGY	1,710	1,710	3,460	0	76.00
76.01 03950	WOUND CARE	0	0	555,803	0	76.01
76.97 07697	CARDIAC REHABILITATION	376	376	142,543	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	40,773	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WOMENS CENTER	0	0	0	0	90.01
90.02 09002	PSYCH SERVICES	0	0	0	0	90.02
90.03 09003	OP BEHAVIORAL HEALTH	7,083	7,083	555,768	0	90.03
90.04 09004	DIABETES CENTER	0	0	0	0	90.04
91.00 09100	EMERGENCY	10,530	10,530	1,823,837	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	336,446	336,446	14,986,086	-11,666,335	29,507,124
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	452	452	0	0	190.00
190.02 19002	CRISIS PROGRAM	1,247	1,247	1,341,672	0	190.02
191.00 19100	RESEARCH	0	0	0	0	191.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,186	2,186	0	0	192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,009,386	2,823,150	4,354,563	11,666,335	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	5.904211	8.295307	0.266697	0.372774	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			0	3,120,105	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000	0.099697	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

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

Worksheet B-1  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
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: 14-0176

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

Worksheet B-1

Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	90,174					6.00
7.00	00700	1,344	88,830				7.00
8.00	00800	760	760	471,594			8.00
9.00	00900	3,391	3,391	0	84,679		9.00
10.00	01000	6,479	6,479	0	6,479	69,532	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	452	452	0	452	0	13.00
14.00	01400	5,160	5,160	0	5,160	0	14.00
15.00	01500	1,669	1,669	0	1,669	0	15.00
16.00	01600	4,873	4,873	0	4,873	0	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	18,815	18,815	110,963	18,815	67,401	30.00
31.00	03100	855	855	0	855	2,131	31.00
40.00	04000	0	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,376	3,376	0	3,376	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	8,459	8,459	110,963	8,459	0	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	537	537	0	537	0	56.00
57.00	05700	1,390	1,390	0	1,390	0	57.00
58.00	05800	1,846	1,846	0	1,846	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	5,902	5,902	0	5,902	0	60.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	926	926	0	926	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	356	356	0	356	0	70.01
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
76.00	03951	1,710	1,710	0	1,710	0	76.00
76.01	03950	0	0	0	0	0	76.01
76.97	07697	376	376	0	376	0	76.97
76.98	07698	0	0	0	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	7,083	7,083	0	7,083	0	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	10,530	10,530	249,668	10,530	0	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		86,289	84,945	471,594	80,794	69,532	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	452	452	0	452	0	190.00
190.02	19002	1,247	1,247	0	1,247	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	2,186	2,186	0	2,186	0	192.00
200.00							200.00
201.00							201.00
202.00		2,807,873	3,003,771	274,865	1,898,718	1,588,138	202.00
203.00		31.138388	33.814826	0.582842	22.422537	22.840390	203.00
204.00		844,399	251,121	36,434	211,387	266,557	204.00
205.00		9.364107	2.826984	0.077257	2.496333	3.833587	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

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

Worksheet B-1

Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING HOURS/FTEs)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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	17,328					11.00
13.00	01300	452	11,583				13.00
14.00	01400	149	0	507,691			14.00
15.00	01500	1,198	0	0	863,786		15.00
16.00	01600	0	0	0	0	155,556,484	16.00
17.00	01700	0	0	0	0	0	17.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	5,029	5,029	0	0	20,098,520	30.00
31.00	03100	206	206	0	0	689,322	31.00
40.00	04000	0	0	0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	301	301	0	0	2,555,791	50.00
53.00	05300	0	0	0	0	199,955	53.00
54.00	05400	1,223	0	0	0	14,026,590	54.00
55.00	05500	0	0	0	0	0	55.00
56.00	05600	77	0	0	0	750,513	56.00
57.00	05700	375	0	0	0	20,785,773	57.00
58.00	05800	135	0	0	0	10,721,214	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	190	0	0	0	12,042,545	60.00
65.00	06500	419	419	0	0	486,866	65.00
66.00	06600	16	0	0	0	79,108	66.00
67.00	06700	11	0	0	0	38,523	67.00
68.00	06800	13	0	0	0	14,277	68.00
70.00	07000	0	0	0	0	0	70.00
70.01	07001	916	916	0	0	9,037,292	70.01
71.00	07100	0	0	507,691	0	972,243	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	863,786	4,749,672	73.00
76.00	03951	4	4	0	0	45,115	76.00
76.01	03950	885	885	0	0	10,550,854	76.01
76.97	07697	182	182	0	0	600,926	76.97
76.98	07698	63	63	0	0	2,052,739	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	849	849	0	0	7,324,297	90.03
90.04	09004	0	0	0	0	0	90.04
91.00	09100	2,729	2,729	0	0	37,734,349	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		15,422	11,583	507,691	863,786	155,556,484	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	0	0	0	0	190.00
190.02	19002	1,906	0	0	0	0	190.02
191.00	19100	0	0	0	0	0	191.00
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		372,392	1,083,715	1,236,758	2,834,394	764,628	202.00
203.00		21.490766	93.560822	2.436045	3.281361	0.004915	203.00
204.00		27,045	88,911	454,349	694,712	165,375	204.00
205.00		1.560769	7.675991	0.894932	0.804264	0.001063	205.00
206.00							206.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

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

Worksheet B-1

Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING HOURS/FTEs)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	11.00	13.00	14.00	15.00	16.00	207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0176

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

Worksheet B-1  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		SOCIAL SERVICE	
		(TIME SPENT)	
		17.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
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
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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03951	CARDIOLOGY	76.00
76.01	03950	WOUND CARE	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
90.01	09001	WOMENS CENTER	90.01
90.02	09002	PSYCH SERVICES	90.02
90.03	09003	OP BEHAVIORAL HEALTH	90.03
90.04	09004	DIABETES CENTER	90.04
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.02	19002	CRISIS PRGRAM	190.02
191.00	19100	RESEARCH	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000
204.00		Cost to be allocated (per Wkst. B, Part II)	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000
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: 14-0176

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XVIII		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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	10,770,199		10,770,199	0	10,770,199	30.00
31.00	03100	INTENSIVE CARE UNIT	482,752		482,752	1,734	484,486	31.00
40.00	04000	SUBPROVIDER - I/PF	0		0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,709,343		2,709,343	0	2,709,343	50.00
53.00	05300	ANESTHESIOLOGY	34,085		34,085	0	34,085	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,375,401		3,375,401	9,775	3,385,176	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0		0	0	0	55.00
56.00	05600	RADIOISOTOPE	301,267		301,267	0	301,267	56.00
57.00	05700	CT SCAN	1,112,420		1,112,420	0	1,112,420	57.00
58.00	05800	MRI	648,786		648,786	0	648,786	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	2,103,346		2,103,346	0	2,103,346	60.00
65.00	06500	RESPIRATORY THERAPY	648,941	0	648,941	0	648,941	65.00
66.00	06600	PHYSICAL THERAPY	151,358	0	151,358	115	151,473	66.00
67.00	06700	OCCUPATIONAL THERAPY	15,812	0	15,812	0	15,812	67.00
68.00	06800	SPEECH PATHOLOGY	19,793	0	19,793	0	19,793	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	1,478,865		1,478,865	8,029	1,486,894	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,938,482		1,938,482	0	1,938,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,043,522		4,043,522	0	4,043,522	73.00
76.00	03951	CARDIOLOGY	195,999		195,999	0	195,999	76.00
76.01	03950	WOUND CARE	2,008,661		2,008,661	3,773	2,012,434	76.01
76.97	07697	CARDIAC REHABILITATION	326,121		326,121	0	326,121	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	248,784		248,784	0	248,784	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOMENS CENTER	0		0	0	0	90.01
90.02	09002	PSYCH SERVICES	0		0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	1,884,267		1,884,267	0	1,884,267	90.03
90.04	09004	DIABETES CENTER	0		0	0	0	90.04
91.00	09100	EMERGENCY	5,627,981		5,627,981	1,629	5,629,610	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	102,960		102,960	0	102,960	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00
200.00		Subtotal (see instructions)	40,229,145	0	40,229,145	25,055	40,254,200	200.00
201.00		Less Observation Beds	102,960		102,960		102,960	201.00
202.00		Total (see instructions)	40,126,185	0	40,126,185	25,055	40,151,240	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0176

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	19,819,128		19,819,128		30.00
31.00	03100	INTENSIVE CARE UNIT	689,322		689,322		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	472,158	2,083,633	2,555,791	1.060080	50.00
53.00	05300	ANESTHESIOLOGY	60,463	139,492	199,955	0.170463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	376,125	13,650,465	14,026,590	0.240643	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	31,776	718,737	750,513	0.401415	56.00
57.00	05700	CT SCAN	733,179	20,052,594	20,785,773	0.053518	57.00
58.00	05800	MRI	118,981	10,602,233	10,721,214	0.060514	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,846,186	9,196,359	12,042,545	0.174660	60.00
65.00	06500	RESPIRATORY THERAPY	203,437	283,429	486,866	1.332894	65.00
66.00	06600	PHYSICAL THERAPY	76,174	2,934	79,108	1.913308	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,032	491	38,523	0.410456	67.00
68.00	06800	SPEECH PATHOLOGY	12,952	1,325	14,277	1.386356	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	2,741	9,034,551	9,037,292	0.163640	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	356,061	616,182	972,243	1.993825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,595,101	3,154,571	4,749,672	0.851327	73.00
76.00	03951	CARDIOLOGY	6,461	38,654	45,115	4.344431	76.00
76.01	03950	WOUND CARE	0	10,550,854	10,550,854	0.190379	76.01
76.97	07697	CARDIAC REHABILITATION	0	600,926	600,926	0.542697	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,052,739	2,052,739	0.121196	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOMENS CENTER	0	0	0	0.000000	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	16,332	7,307,965	7,324,297	0.257263	90.03
90.04	09004	DIABETES CENTER	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	2,888,379	34,845,970	37,734,349	0.149147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	279,392	279,392	0.368514	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	30,342,988	125,213,496	155,556,484		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	30,342,988	125,213,496	155,556,484		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.060080	50.00
53.00	05300	ANESTHESIOLOGY	0.170463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241340	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.401415	56.00
57.00	05700	CT SCAN	0.053518	57.00
58.00	05800	MRI	0.060514	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.174660	60.00
65.00	06500	RESPIRATORY THERAPY	1.332894	65.00
66.00	06600	PHYSICAL THERAPY	1.914762	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.410456	67.00
68.00	06800	SPEECH PATHOLOGY	1.386356	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.164529	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.993825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.851327	73.00
76.00	03951	CARDIOLOGY	4.344431	76.00
76.01	03950	WOUND CARE	0.190737	76.01
76.97	07697	CARDIAC REHABILITATION	0.542697	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.121196	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOMENS CENTER	0.000000	90.01
90.02	09002	PSYCH SERVICES	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.257263	90.03
90.04	09004	DIABETES CENTER	0.000000	90.04
91.00	09100	EMERGENCY	0.149191	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.368514	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0176

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XIX		Hospital		Cost	
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		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	10,770,199		10,770,199	0	10,770,199	30.00
31.00	03100 INTENSIVE CARE UNIT	482,752		482,752	1,734	484,486	31.00
40.00	04000 SUBPROVIDER - I/PF	0		0	0	0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	2,709,343		2,709,343	0	2,709,343	50.00
53.00	05300 ANESTHESIOLOGY	34,085		34,085	0	34,085	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,375,401		3,375,401	9,775	3,385,176	54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0		0	0	0	55.00
56.00	05600 RADIOISOTOPE	301,267		301,267	0	301,267	56.00
57.00	05700 CT SCAN	1,112,420		1,112,420	0	1,112,420	57.00
58.00	05800 MRI	648,786		648,786	0	648,786	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	2,103,346		2,103,346	0	2,103,346	60.00
65.00	06500 RESPIRATORY THERAPY	648,941	0	648,941	0	648,941	65.00
66.00	06600 PHYSICAL THERAPY	151,358	0	151,358	115	151,473	66.00
67.00	06700 OCCUPATIONAL THERAPY	15,812	0	15,812	0	15,812	67.00
68.00	06800 SPEECH PATHOLOGY	19,793	0	19,793	0	19,793	68.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70.01	07001 SLEEP LAB/NEUROLOGY	1,478,865		1,478,865	8,029	1,486,894	70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,938,482		1,938,482	0	1,938,482	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,043,522		4,043,522	0	4,043,522	73.00
76.00	03951 CARDIOLOGY	195,999		195,999	0	195,999	76.00
76.01	03950 WOUND CARE	2,008,661		2,008,661	3,773	2,012,434	76.01
76.97	07697 CARDIAC REHABILITATION	326,121		326,121	0	326,121	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	248,784		248,784	0	248,784	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0		0	0	0	90.00
90.01	09001 WOMENS CENTER	0		0	0	0	90.01
90.02	09002 PSYCH SERVICES	0		0	0	0	90.02
90.03	09003 OP BEHAVIORAL HEALTH	1,884,267		1,884,267	0	1,884,267	90.03
90.04	09004 DIABETES CENTER	0		0	0	0	90.04
91.00	09100 EMERGENCY	5,627,981		5,627,981	1,629	5,629,610	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	102,960		102,960	0	102,960	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	40,229,145	0	40,229,145	25,055	40,254,200	200.00
201.00	Less Observation Beds	102,960		102,960		102,960	201.00
202.00	Total (see instructions)	40,126,185	0	40,126,185	25,055	40,151,240	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0176

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	19,819,128		19,819,128		30.00
31.00	03100	INTENSIVE CARE UNIT	689,322		689,322		31.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	472,158	2,083,633	2,555,791	1.060080	50.00
53.00	05300	ANESTHESIOLOGY	60,463	139,492	199,955	0.170463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	376,125	13,650,465	14,026,590	0.240643	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	31,776	718,737	750,513	0.401415	56.00
57.00	05700	CT SCAN	733,179	20,052,594	20,785,773	0.053518	57.00
58.00	05800	MRI	118,981	10,602,233	10,721,214	0.060514	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,846,186	9,196,359	12,042,545	0.174660	60.00
65.00	06500	RESPIRATORY THERAPY	203,437	283,429	486,866	1.332894	65.00
66.00	06600	PHYSICAL THERAPY	76,174	2,934	79,108	1.913308	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,032	491	38,523	0.410456	67.00
68.00	06800	SPEECH PATHOLOGY	12,952	1,325	14,277	1.386356	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	2,741	9,034,551	9,037,292	0.163640	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	356,061	616,182	972,243	1.993825	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,595,101	3,154,571	4,749,672	0.851327	73.00
76.00	03951	CARDIOLOGY	6,461	38,654	45,115	4.344431	76.00
76.01	03950	WOUND CARE	0	10,550,854	10,550,854	0.190379	76.01
76.97	07697	CARDIAC REHABILITATION	0	600,926	600,926	0.542697	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	2,052,739	2,052,739	0.121196	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WOMENS CENTER	0	0	0	0.000000	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	16,332	7,307,965	7,324,297	0.257263	90.03
90.04	09004	DIABETES CENTER	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	2,888,379	34,845,970	37,734,349	0.149147	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	279,392	279,392	0.368514	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	30,342,988	125,213,496	155,556,484		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	30,342,988	125,213,496	155,556,484		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/16/2018 9:27 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03951	CARDIOLOGY	0.000000	76.00
76.01	03950	WOUND CARE	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOMENS CENTER	0.000000	90.01
90.02	09002	PSYCH SERVICES	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.000000	90.03
90.04	09004	DIABETES CENTER	0.000000	90.04
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part I Date/Time Prepared: 11/16/2018 9:27 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,375,360	0	1,375,360	7,950	173.00	30.00
31.00	INTENSIVE CARE UNIT	59,634		59,634	249	239.49	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
200.00	Total (Lines 30 through 199)	1,434,994		1,434,994	8,199		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	2,208	381,984				
31.00	INTENSIVE CARE UNIT	113	27,062				
40.00	SUBPROVIDER - IPF	0	0				
200.00	Total (Lines 30 through 199)	2,321	409,046				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0176

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

Worksheet D  
Part II  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	281,024	2,555,791	0.109956	276,698	30,425	50.00
53.00	05300	ANESTHESIOLOGY	2,617	199,955	0.013088	29,698	389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	449,593	14,026,590	0.032053	193,067	6,188	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0.000000	0	0	55.00
56.00	05600	RADIOISOTOPE	34,516	750,513	0.045990	24,276	1,116	56.00
57.00	05700	CT SCAN	127,278	20,785,773	0.006123	446,977	2,737	57.00
58.00	05800	MRI	96,299	10,721,214	0.008982	35,294	317	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	294,296	12,042,545	0.024438	1,081,270	26,424	60.00
65.00	06500	RESPIRATORY THERAPY	48,978	486,866	0.100599	161,361	16,233	65.00
66.00	06600	PHYSICAL THERAPY	31,921	79,108	0.403512	54,109	21,834	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,176	38,523	0.030527	26,746	816	67.00
68.00	06800	SPEECH PATHOLOGY	1,447	14,277	0.101352	11,605	1,176	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	197,996	9,037,292	0.021909	914	20	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	505,997	972,243	0.520443	143,756	74,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	785,878	4,749,672	0.165459	718,475	118,878	73.00
76.00	03951	CARDIOLOGY	52,816	45,115	1.170697	6,461	7,564	76.00
76.01	03950	WOUND CARE	271,945	10,550,854	0.025775	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	32,745	600,926	0.054491	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	52,818	2,052,739	0.025730	0	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0.000000	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0.000000	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	302,476	7,324,297	0.041298	16,332	674	90.03
90.04	09004	DIABETES CENTER	0	0	0.000000	0	0	90.04
91.00	09100	EMERGENCY	708,009	37,734,349	0.018763	1,091,553	20,481	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	13,148	279,392	0.047059	0	0	92.00
200.00		Total (lines 50 through 199)	4,292,973	135,048,034		4,318,592	330,089	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/16/2018 9:27 am		
			Title XVIII		Hospital		PPS	

Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
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	7,950	0.00	2,208	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	249	0.00	113	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
200.00		Total (lines 30 through 199)	0	0	8,199		2,321	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
			9.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
200.00		Total (lines 30 through 199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0176

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/16/2018 9:27 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	0	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03951	CARDIOLOGY	0	0	0	0	0	76.00
76.01	03950	WOUND CARE	0	0	0	0	0	76.01
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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0	0	0	0	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0	90.04
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0176

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/16/2018 9:27 am

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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	2,555,791	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	199,955	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	14,026,590	0.000000	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	750,513	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	20,785,773	0.000000	57.00
58.00	05800	MRI	0	0	0	10,721,214	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	12,042,545	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	486,866	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	79,108	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	38,523	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	14,277	0.000000	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0	0	0	9,037,292	0.000000	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	972,243	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,749,672	0.000000	73.00
76.00	03951	CARDIOLOGY	0	0	0	45,115	0.000000	76.00
76.01	03950	WOUND CARE	0	0	0	10,550,854	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	600,926	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	2,052,739	0.000000	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09001	WOMENS CENTER	0	0	0	0	0.000000	90.01
90.02	09002	PSYCH SERVICES	0	0	0	0	0.000000	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0	0	0	7,324,297	0.000000	90.03
90.04	09004	DIABETES CENTER	0	0	0	0	0.000000	90.04
91.00	09100	EMERGENCY	0	0	0	37,734,349	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	279,392	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	135,048,034		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/16/2018 9:27 am
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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	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.000000	276,698	0	712,141	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	29,698	0	20,520	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	193,067	0	2,796,650	0	54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	24,276	0	263,128	0	56.00
57.00	05700	CT SCAN	0.000000	446,977	0	5,655,173	0	57.00
58.00	05800	MRI	0.000000	35,294	0	3,456,014	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,081,270	0	1,639,795	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	161,361	0	79,501	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	54,109	0	2,029	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	26,746	0	491	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	11,605	0	673	0	68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.000000	914	0	2,796,766	0	70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	143,756	0	148,497	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	718,475	0	1,353,659	0	73.00
76.00	03951	CARDIOLOGY	0.000000	6,461	0	12,126	0	76.00
76.01	03950	WOUND CARE	0.000000	0	0	4,686,376	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	332,626	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	1,264,592	0	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOMENS CENTER	0.000000	0	0	0	0	90.01
90.02	09002	PSYCH SERVICES	0.000000	0	0	0	0	90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.000000	16,332	0	1,094,240	0	90.03
90.04	09004	DIABETES CENTER	0.000000	0	0	0	0	90.04
91.00	09100	EMERGENCY	0.000000	1,091,553	0	6,151,399	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	49,282	0	92.00
200.00		Total (lines 50 through 199)		4,318,592	0	32,515,678	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/16/2018 9:27 am
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Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	Title XVIII	Hospital	PPS
ANCILLARY SERVICE COST CENTERS		21.00	24.00			
50.00	05000 OPERATING ROOM	0	0			50.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
55.00	05500 RADIOLOGY - THERAPEUTIC	0	0			55.00
56.00	05600 RADIOISOTOPE	0	0			56.00
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MRI	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
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
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
70.01	07001 SLEEP LAB/NEUROLOGY	0	0			70.01
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
76.00	03951 CARDIOLOGY	0	0			76.00
76.01	03950 WOUND CARE	0	0			76.01
76.97	07697 CARDIAC REHABILITATION	0	0			76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0			76.98
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0			90.00
90.01	09001 WOMENS CENTER	0	0			90.01
90.02	09002 PSYCH SERVICES	0	0			90.02
90.03	09003 OP BEHAVIORAL HEALTH	0	0			90.03
90.04	09004 DIABETES CENTER	0	0			90.04
91.00	09100 EMERGENCY	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
200.00	Total (lines 50 through 199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	1.060080	712,141	0	0	754,926	50.00
53.00 05300 ANESTHESIOLOGY	0.170463	20,520	0	0	3,498	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.240643	2,796,650	0	0	672,994	54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00 05600 RADIOISOTOPE	0.401415	263,128	0	0	105,624	56.00
57.00 05700 CT SCAN	0.053518	5,655,173	0	0	302,654	57.00
58.00 05800 MRI	0.060514	3,456,014	0	0	209,137	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.174660	1,639,795	0	0	286,407	60.00
65.00 06500 RESPIRATORY THERAPY	1.332894	79,501	0	0	105,966	65.00
66.00 06600 PHYSICAL THERAPY	1.913308	2,029	0	0	3,882	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.410456	491	0	0	202	67.00
68.00 06800 SPEECH PATHOLOGY	1.386356	673	0	0	933	68.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0.163640	2,796,766	0	0	457,663	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.993825	148,497	0	0	296,077	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	0.851327	1,353,659	0	221	1,152,406	73.00
76.00 03951 RADIOLOGY	4.344431	12,126	0	0	52,681	76.00
76.01 03950 WOUND CARE	0.190379	4,686,376	0	0	892,188	76.01
76.97 07697 CARDIAC REHABILITATION	0.542697	332,626	0	0	180,515	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.121196	1,264,592	0	0	153,263	76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.000000	0	0	0	0	90.00
90.01 09001 WOMENS CENTER	0.000000	0	0	0	0	90.01
90.02 09002 PSYCH SERVICES	0.000000	0	0	0	0	90.02
90.03 09003 OP BEHAVIORAL HEALTH	0.257263	1,094,240	0	0	281,507	90.03
90.04 09004 DIABETES CENTER	0.000000	0	0	0	0	90.04
91.00 09100 EMERGENCY	0.149147	6,151,399	0	0	917,463	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.368514	49,282	0	0	18,161	92.00
200.00 Subtotal (see instructions)		32,515,678	0	221	6,848,147	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00 Net Charges (line 200 - line 201)		32,515,678	0	221	6,848,147	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/16/2018 9:27 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00 05500 RADIOLOGY - THERAPEUTIC	0	0		55.00
56.00 05600 RADIOISOTOPE	0	0		56.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70.01 07001 SLEEP LAB/NEUROLOGY	0	0		70.01
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	188		73.00
76.00 03951 CARDIOLOGY	0	0		76.00
76.01 03950 WOUND CARE	0	0		76.01
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOMENS CENTER	0	0		90.01
90.02 09002 PSYCH SERVICES	0	0		90.02
90.03 09003 OP BEHAVIORAL HEALTH	0	0		90.03
90.04 09004 DIABETES CENTER	0	0		90.04
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	188		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	188		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/16/2018 9:27 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,950	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,950	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)		7,874	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)		2,208	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,770,199	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,770,199	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,770,199	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,354.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,991,266	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)		2,991,266	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/16/2018 9:27 am	
Cost Center Description			Title XVIII		Hospital	
			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	
			1.00	2.00	3.00	
					Program Days	
					Program Cost (col. 3 x col. 4)	
					4.00	
					5.00	
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	484,486	249	1,945.73	113	219,867
44.00	CORONARY CARE UNIT					43.00
45.00	BURN INTENSIVE CARE UNIT					44.00
46.00	SURGICAL INTENSIVE CARE UNIT					45.00
47.00	OTHER SPECIAL CARE (SPECIFY)					46.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,008,938
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					48.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					409,046
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					330,089
52.00	Total Program excludable cost (sum of lines 50 and 51)					739,135
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,480,936
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
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
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
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
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
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
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
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					76
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,354.74
89.00	Observation bed cost (line 87 x line 88) (see instructions)					102,960

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/16/2018 9:27 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,375,360	10,770,199	0.127701	102,960	13,148	90.00
91.00	Nursing School cost	0	10,770,199	0.000000	102,960	0	91.00
92.00	Allied health cost	0	10,770,199	0.000000	102,960	0	92.00
93.00	All other Medical Education	0	10,770,199	0.000000	102,960	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/16/2018 9:27 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		5,546,826	30.00
31.00	03100	INTENSIVE CARE UNIT		395,321	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	1.060080	276,698	293,322 50.00
53.00	05300	ANESTHESIOLOGY	0.170463	29,698	5,062 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.241340	193,067	46,595 54.00
55.00	05500	RADIOLOGY - THERAPEUTIC	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	0.401415	24,276	9,745 56.00
57.00	05700	CT SCAN	0.053518	446,977	23,921 57.00
58.00	05800	MRI	0.060514	35,294	2,136 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.174660	1,081,270	188,855 60.00
65.00	06500	RESPIRATORY THERAPY	1.332894	161,361	215,077 65.00
66.00	06600	PHYSICAL THERAPY	1.914762	54,109	103,606 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.410456	26,746	10,978 67.00
68.00	06800	SPEECH PATHOLOGY	1.386356	11,605	16,089 68.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0 70.00
70.01	07001	SLEEP LAB/NEUROLOGY	0.164529	914	150 70.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.993825	143,756	286,624 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.851327	718,475	611,657 73.00
76.00	03951	CARDIOLOGY	4.344431	6,461	28,069 76.00
76.01	03950	WOUND CARE	0.190737	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0.542697	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.121196	0	0 76.98
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000	0	0 90.00
90.01	09001	WOMENS CENTER	0.000000	0	0 90.01
90.02	09002	PSYCH SERVICES	0.000000	0	0 90.02
90.03	09003	OP BEHAVIORAL HEALTH	0.257263	16,332	4,202 90.03
90.04	09004	DIABETES CENTER	0.000000	0	0 90.04
91.00	09100	EMERGENCY	0.149191	1,091,553	162,850 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.368514	0	0 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,318,592	2,008,938 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		4,318,592	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
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)		1,277,611	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		1,139,812	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)		66,574	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)		44.02	4.00
<b>Indirect Medical Education Adjustment</b>				
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
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
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
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.10	30.00
31.00	Percentage of Medicaid patient days (see instructions)		36.91	31.00
32.00	Sum of lines 30 and 31		40.01	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		72,522	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/16/2018 9:27 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000112430	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		708,684	760,780	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		178,627	569,022	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		747,649		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		3,304,168		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
				<b>Amount</b>	
				<b>1.00</b>	
49.00	Total payment for inpatient operating costs (see instructions)			3,304,168	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			202,794	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			3,506,962	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,506,962	61.00
62.00	Deductibles billed to program beneficiaries			259,136	62.00
63.00	Coinurance billed to program beneficiaries			25,519	63.00
64.00	Allowable bad debts (see instructions)			316,632	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			205,811	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			170,555	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3,428,118	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			-103	70.93
70.94	HRR adjustment amount (see instructions)			-3,511	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,424,504	71.00
71.01	Sequestration adjustment (see instructions)		68,490	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		2,751,103	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)		604,911	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
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
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)		0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>				
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
<b>HRR Adjustment for HSP Bonus Payment</b>				
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
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>				
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
<b>Cost Reimbursement</b>				
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
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
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
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
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
<b>Comparison of PPS versus Cost Reimbursement</b>				
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 DSH PAYMENT PERCENTAGE		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet DSH	
		Title XVIII		Hospital		PPS	
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF THE DSH PAYMENT PERCENTAGE</b>							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	3.10	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	36.91	0.00			36.91	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	40.01	0.00			36.91	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	44.02	0.00			44.02	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12.00	0.00			19.67	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
<b>CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS</b>							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	843	0			843	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	545	0			545	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	1,610	0			1,610	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	2,998	0			2,998	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	8,123	0			8,123	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	8,123	0			8,123	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	36.91	0.00			36.91	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet DSH Date/Time Prepared: 11/16/2018 9:27 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
<b>CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE</b>							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	22.22		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		22.22		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		22.22		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
<b>DETERMINATION OF PROVIDER TYPE</b>							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet DSH Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS

		Revised	
		Percentage	
		6.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	19.67	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00	29.00
30.00	Line 28 or 29 as applicable	19.67	30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	19.67	31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0176

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,277,611	0	1,277,611		1,277,611	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,139,812	0		1,139,812	1,139,812	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	66,574	0	64,986	1,588	66,574	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	72,522	0	38,328	34,194	72,522	11.00
11.01	Uncompensated care payments	36.00	747,649	0	178,627	569,022	747,649	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,304,168	0	1,559,552	1,744,616	3,304,168	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,304,168	0	1,559,552	1,744,616	3,304,168	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	202,794	0	109,770	93,024	202,794	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0176

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,669,322	1,837,640	3,506,962	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	196,241	0	103,409	92,832	196,241	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	6,553	0	6,361	192	6,553	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	202,794	0	109,770	93,024	202,794	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0176		Period: From 07/01/2017 To 06/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/16/2018 9:27 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,277,611	1,277,611		1,277,611	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,139,812		1,139,812	1,139,812	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	66,574	64,986	1,588	66,574	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	72,522	38,328	34,194	72,522	11.00
11.01	Uncompensated care payments	36.00	747,649	178,627	569,022	747,649	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	3,304,168	1,559,552	1,744,616	3,304,168	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,304,168	1,559,552	1,744,616	3,304,168	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	202,794	109,770	93,024	202,794	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	<b>SUBTOTAL</b>			1,669,322	1,837,640	3,506,962	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0176

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

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	196,241	103,409	92,832	196,241	20.00	
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01	
21.00	Capital DRG outlier payments	2.00	6,553	6,361	192	6,553	21.00	
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01	
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	202,794	109,770	93,024	202,794	26.00	
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)					
		0	1.00	2.00	3.00	4.00		
27.00							27.00	
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00	
30.00	HVBP payment adjustment (see instructions)	70.93	-103	1,001	-1,104	-103	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	-3,511	-1,916	-1,595	-3,511	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		188	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,848,147	2.00
3.00	OPPS payments		4,515,973	3.00
4.00	Outlier payment (see instructions)		3,655	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)		188	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		221	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)		221	14.00
<b>Customary charges</b>				
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)		221	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		33	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)		188	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)		4,519,628	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
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)		941,948	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)		3,577,868	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)		3,577,868	30.00
31.00	Primary payer payments		975	31.00
32.00	Subtotal (line 30 minus line 31)		3,576,893	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		335,025	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		217,766	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		216,406	36.00
37.00	Subtotal (see instructions)		3,794,659	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-187	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)		3,794,846	40.00
40.01	Sequestration adjustment (see instructions)		75,897	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		3,789,270	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-70,321	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital
			PPS Overrides
WORKSHEET OVERRIDE VALUES			1.00
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0176

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/16/2018 9:27 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,751,103		3,789,270	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)		2,751,103		3,789,270	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		604,911		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		70,321	6.02	
7.00	Total Medicare program liability (see instructions)		3,356,014		3,718,949	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00
				Overrides
				1.00
<b>CONTRACTOR OVERRIDES</b>				
108.00	Override of HIT payment			108.00

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

Provider CCN: 14-0176

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

Worksheet G  
Date/Time Prepared:  
11/16/2018 9:27 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	-13,000	0	0	0	1.00
2.00	Temporary investments	3,891,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,238,000	0	0	0	4.00
5.00	Other receivable	50,915,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	355,000	0	0	0	7.00
8.00	Prepaid expenses	138,000	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	62,524,000	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	219,885	0	0	0	12.00
13.00	Land improvements	3,212,830	0	0	0	13.00
14.00	Accumulated depreciation	-2,213,317	0	0	0	14.00
15.00	Buildings	75,004,927	0	0	0	15.00
16.00	Accumulated depreciation	-54,955,151	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	49,315,456	0	0	0	23.00
24.00	Accumulated depreciation	-44,680,611	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	9,336,651	0	0	0	27.00
28.00	Accumulated depreciation	-6,978,670	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)	28,262,000	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	31,075,000	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	3,815,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	34,890,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	125,676,000	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	287,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,387,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,728,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,742,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,144,000	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	70,444,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	809,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	71,253,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	81,397,000	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	44,279,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	44,279,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	125,676,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0176

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

Worksheet G-1

Date/Time Prepared:  
11/16/2018 9:27 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		53,538,000			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-7,904,000				2.00
3.00	Total (sum of line 1 and line 2)		45,634,000			0	3.00
4.00	UNRESTRICTED NET ASSETS RELEASED	7,000		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)		7,000			0	10.00
11.00	Subtotal (line 3 plus line 10)		45,641,000			0	11.00
12.00	CHANGES IN UNREALIZED LOSSES	-51,000		0		0	12.00
13.00	CHANGES IN TEMP RESTRICTED ASSETS	1,413,000		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)		1,362,000			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		44,279,000			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	UNRESTRICTED NET ASSETS RELEASED		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	CHANGES IN UNREALIZED LOSSES		0				12.00
13.00	CHANGES IN TEMP RESTRICTED ASSETS		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: 14-0176

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/16/2018 9:27 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	19,819,128		19,819,128	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	19,819,128		19,819,128	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	689,322		689,322	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)	689,322		689,322	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	20,508,450		20,508,450	17.00
18.00	Ancillary services	6,929,825	82,780,169	89,709,994	18.00
19.00	Outpatient services	2,904,711	42,433,327	45,338,038	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	CRISIS PROGRAM	0	1,378,765	1,378,765	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	30,342,986	126,592,261	156,935,247	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		55,561,854		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)		55,561,854		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0176

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

Worksheet G-3

Date/Time Prepared:  
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	156,935,247	1.00
2.00	Less contractual allowances and discounts on patients' accounts	113,202,247	2.00
3.00	Net patient revenues (line 1 minus line 2)	43,733,000	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	55,561,854	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-11,828,854	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	-40,064	6.00
7.00	Income from investments	1,814,484	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	<b>OTHER REVENUE</b>	2,150,173	24.00
24.01	<b>ROUNDING</b>	261	24.01
25.00	Total other income (sum of lines 6-24)	3,924,854	25.00
26.00	Total (line 5 plus line 25)	-7,904,000	26.00
27.00	<b>OTHER EXPENSES (SPECIFY)</b>	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-7,904,000	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0176	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/16/2018 9:27 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		196,241	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		6,553	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)		22.25	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		202,794	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
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
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
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