

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 3:54 pm							
1.00		2.00		3.00		4.00										
Hospital and Hospital Health Care Complex Address:																
1.00	Street: 2233 WEST DIVISION STREET				PO Box:				1.00							
2.00	City: CHICAGO		State: IL		Zip Code: 60622		County: COOK				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	PRESENCE SAINTS MARY & ELI ZABETH MED			140180	16974	1	07/01/1966	N	P	O	3.00				
4.00	Subprovider - IPF	PRESENCE ST MARY AND ELI ZABETH PSYCH			14S180	16974	4	01/01/2018	N	P	O	4.00				
5.00	Subprovider - IRF	ST. MARY OF NAZARETH REHAB UNIT			14T180	16974	5	01/01/1984	N	P	O	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	ST. ELI ZABETH'S SNF			145541	16974		01/28/1986	N	P	N	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 - FOHC											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)						01/01/2018		06/30/2018		20.00					
21.00	Type of Control (see instructions)						1				21.00					
Inpatient PPS Information																
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						Y		N		22.00					
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						Y		Y		22.01					
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N		N		22.02					
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N		N		22.03					
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.								3		N	23.00				
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.						10,264		3,089		0		0	9,377	245	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.						133		0		0		0	503		25.00

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		Urban/Rural	St	Date of Geogra		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00
		Y/N	Y/N			
		1.00	2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N		N		40.00
		V	XVIII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code		
		1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y				60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01
		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.						0.00	0.00	61.10	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						0.00	0.00	61.20	
						1.00				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings						0.00	62.01		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						N	63.00		
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
	1.00		2.00	3.00	4.00	5.00				
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						0.00	0.00	0.000000	64.00

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

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

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		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00			
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	3,336,114		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	Y		5.00		122.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H082		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 3:54 pm							
1.00		2.00		3.00									
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.													
141.00	Name: PRESENCE CARE TRANSFORMATION CORP	Contractor's Name: NGS		Contractor's Number: 00131				141.00					
142.00	Street: 200 SOUTH WACKER DRIVE	PO Box:						142.00					
143.00	City: CHICAGO	State: IL		Zip Code: 60606				143.00					
144.00 Are provider based physicians' costs included in Worksheet A?													
Y													
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.													
N													
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.													
N													
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.													
N													
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.													
N													
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.													
N													
		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			
165.00 Multi campus 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)												
												0.00	
167.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.													
Y													
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)												
												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)												
												9.99	
								Beginn ing		Endi ng			
								1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)												
								01/01/2018		06/30/2018			
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)													
								N					
												0	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 3:54 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				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.	Y					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.	Y					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.	Y					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	11/05/2018	Y	11/05/2018		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: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 3:54 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N	N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		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	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK		GILLI LAND	41.00
42.00	Enter the employer/company name of the cost report preparer	AMI TA HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847-813-3718		PATRICK.GILLI LAND@AMITAEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0180

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

Worksheet S-2
Part II
Date/Time Prepared:
11/28/2018 3:54 pm

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0180

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	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	344	62,264	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)		344	62,264	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	26	4,706	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		370	66,970	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	2,534		0	16.00
17.00 SUBPROVIDER - IRF	41.00	15	2,715		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	30	5,430		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		429				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)		8	1,448			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: 14-0180

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents			
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll		
	6.00	7.00	8.00	9.00	10.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,914	6,870	40,498			1.00
2.00	HMO and other (see instructions)	3,662	14,820				2.00
3.00	HMO IPF Subprovider	365	525				3.00
4.00	HMO IRF Subprovider	205	487				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	9,914	6,870	40,498			7.00
8.00	INTENSIVE CARE UNIT	746	214	2,359			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		838	1,545			13.00
14.00	Total (see instructions)	10,660	7,922	44,402	54.65	1,307.26	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	846	253	2,296	0.00	22.49	16.00
17.00	SUBPROVIDER - IRF	888	146	2,167	0.00	16.80	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,681	104	3,723	0.00	31.73	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)				54.65	1,378.28	27.00
28.00	Observation Bed Days		0	2,264			28.00
29.00	Ambulance Trips	0		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	233	304			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			3			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: 14-0180

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,886	1,076	8,556	1.00
2.00	HMO and other (see instructions)			715	3,508		2.00
3.00	HMO IPF Subprovider				75		3.00
4.00	HMO IRF Subprovider				43		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,886	1,076	8,556	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	104	16	294	16.00
17.00	SUBPROVIDER - IRF	0.00	0	69	3	175	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet S-3 Part II Date/Time Prepared: 11/28/2018 3:54 pm		
	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)			
	1.00	2.00	3.00	4.00	5.00	6.00			
PART II - WAGE DATA									
SALARIES									
1.00	Total salaries (see instructions)	200.00	48,769,758	69,142	48,838,900	1,433,408.00	34.07		
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		494,257	0	494,257	4,561.00	108.37		
4.01	Physicians - Part A - Teaching		819,503	0	819,503	8,180.00	100.18		
5.00	Physician and Non-Physician-Part B		891,123	0	891,123	6,735.00	132.31		
6.00	Non-physician-Part B for hospital-based RHC and FOHC services		0	0	0	0.00	0.00		
7.00	Interns & residents (in an approved program)	21.00	0	1,290,676	1,290,676	47,043.00	27.44		
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	1,271,439	0	1,271,439	32,999.00	38.53		
10.00	Excluded area salaries (see instructions)		1,415,326	11,856	1,427,182	44,208.00	32.28		
OTHER WAGES & RELATED COSTS									
11.00	Contract Labor: Direct Patient Care		4,351,696	0	4,351,696	103,140.00	42.19		
12.00	Contract labor: Top level management and other management and administrative services		3,157,277	0	3,157,277	65,728.00	48.04		
13.00	Contract Labor: Physician-Part A - Administrative		38,188	0	38,188	150.00	254.59		
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		11,162,682	0	11,162,682	274,676.00	40.64		
14.02	Related organization salaries		0	0	0	0.00	0.00		
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00		
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00		
WAGE-RELATED COSTS									
17.00	Wage-related costs (core) (see instructions)		11,289,017	0	11,289,017				
18.00	Wage-related costs (other) (see instructions)		0	0	0				
19.00	Excluded areas		696,523	0	696,523				
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		93,801	0	93,801				
22.01	Physician Part A - Teaching		163,552	0	163,552				
23.00	Physician Part B		149,782	0	149,782				
24.00	Wage-related costs (RHC/FOHC)		0	0	0				
25.00	Interns & residents (in an approved program)		283,948	0	283,948				
25.50	Home office wage-related (core)		2,450,921	0	2,450,921				
25.51	Related organization wage-related (core)		0	0	0				
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0				
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0				
OVERHEAD COSTS - DIRECT SALARIES									
26.00	Employee Benefits Department	4.00	-69,142	69,142	0	0.00	0.00		
27.00	Administrative & General	5.00	4,943,354	0	4,943,354	148,207.00	33.35		
28.00	Administrative & General under contract (see inst.)		3,344,320	0	3,344,320	18,038.00	185.40		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0180

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

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2018 3:54 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
29.00	Maintenance & Repairs	6.00	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,281,860	-11,856	1,270,004	33,753.00	37.63 30.00
31.00	Laundry & Linen Service	8.00	56,686	0	56,686	4,364.00	12.99 31.00
32.00	Housekeeping	9.00	933,550	0	933,550	62,989.00	14.82 32.00
33.00	Housekeeping under contract (see instructions)		416,538	0	416,538	14,365.00	29.00 33.00
34.00	Dietary	10.00	991,044	-552,458	438,586	30,620.00	14.32 34.00
35.00	Dietary under contract (see instructions)		573,325	0	573,325	12,379.00	46.31 35.00
36.00	Cafeteria	11.00	0	552,458	552,458	38,571.00	14.32 36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00 37.00
38.00	Nursing Administration	13.00	896,670	0	896,670	19,974.00	44.89 38.00
39.00	Central Services and Supply	14.00	166,482	0	166,482	8,328.00	19.99 39.00
40.00	Pharmacy	15.00	2,023,309	0	2,023,309	47,453.00	42.64 40.00
41.00	Medical Records & Medical Records Library	16.00	23,196	0	23,196	1,040.00	22.30 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: 14-0180

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

Worksheet S-3
Part III
Date/Time Prepared:
11/28/2018 3:54 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	51,393,315	-1,221,534	50,171,781	1,416,232.00	35.43	1.00
2.00	Excluded area salaries (see instructions)	2,686,765	11,856	2,698,621	77,207.00	34.95	2.00
3.00	Subtotal salaries (line 1 minus line 2)	48,706,550	-1,233,390	47,473,160	1,339,025.00	35.45	3.00
4.00	Subtotal other wages & related costs (see inst.)	18,709,843	0	18,709,843	443,694.00	42.17	4.00
5.00	Subtotal wage-related costs (see inst.)	13,833,739	0	13,833,739	0.00	29.14	5.00
6.00	Total (sum of lines 3 thru 5)	81,250,132	-1,233,390	80,016,742	1,782,719.00	44.88	6.00
7.00	Total overhead cost (see instructions)	15,581,192	57,286	15,638,478	440,081.00	35.54	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2018 3:54 pm
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		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,926,533	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)	1,396,258	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration Fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	4,789,499	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	112,269	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	30,163	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)	154,219	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	560,733	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,542,635	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	48,978	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	115,336	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	12,676,623	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet S-3 Part V Date/Time Prepared: 11/28/2018 3:54 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	4,351,696	12,676,623	1.00
2.00	Hospital	4,351,696	11,289,017	2.00
3.00	Subprovider - IPF	0	210,968	3.00
4.00	Subprovider - IRF	0	157,642	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	1,018,996	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0180

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

Worksheet S-7

Date/Time Prepared:
11/28/2018 3:54 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
3.00	RUX	75	0	75	3.00
4.00	RUL	74	0	74	4.00
5.00	RVX	0	0	0	5.00
6.00	RVL	14	0	14	6.00
7.00	RHX	0	0	0	7.00
8.00	RHL	4	0	4	8.00
9.00	RMX	0	0	0	9.00
10.00	RML	0	0	0	10.00
11.00	RLX	0	0	0	11.00
12.00	RUC	313	0	313	12.00
13.00	RUB	1,659	0	1,659	13.00
14.00	RUA	386	0	386	14.00
15.00	RVC	36	0	36	15.00
16.00	RVB	34	0	34	16.00
17.00	RVA	29	0	29	17.00
18.00	RHC	0	0	0	18.00
19.00	RHB	3	0	3	19.00
20.00	RHA	0	0	0	20.00
21.00	RMC	0	0	0	21.00
22.00	RMB	0	0	0	22.00
23.00	RMA	0	0	0	23.00
24.00	RLB	0	0	0	24.00
25.00	RLA	0	0	0	25.00
26.00	ES3	0	0	0	26.00
27.00	ES2	0	0	0	27.00
28.00	ES1	7	0	7	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	0	0	0	30.00
31.00	HD2	0	0	0	31.00
32.00	HD1	0	0	0	32.00
33.00	HC2	0	0	0	33.00
34.00	HC1	0	0	0	34.00
35.00	HB2	0	0	0	35.00
36.00	HB1	9	0	9	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	0	0	0	38.00
39.00	LD2	0	0	0	39.00
40.00	LD1	0	0	0	40.00
41.00	LC2	0	0	0	41.00
42.00	LC1	20	0	20	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	3	0	3	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	0	0	0	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	0	0	0	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	0	0	0	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	5	0	5	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	9	0	9	54.00
55.00	SE3	0	0	0	55.00
56.00	SE2	0	0	0	56.00
57.00	SE1	0	0	0	57.00
58.00	SSC	0	0	0	58.00
59.00	SSB	0	0	0	59.00
60.00	SSA	0	0	0	60.00
61.00	IB2	0	0	0	61.00
62.00	IB1	0	0	0	62.00
63.00	IA2	0	0	0	63.00
64.00	IA1	0	0	0	64.00
65.00	BB2	0	0	0	65.00
66.00	BB1	0	0	0	66.00
67.00	BA2	0	0	0	67.00
68.00	BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0180

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

Worksheet S-7

Date/Time Prepared:
11/28/2018 3:54 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		2,681	0	2,681	200.00

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

201.00	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	16974	16974	201.00

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

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

202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	4,092,349			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/28/2018 3:54 pm	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.198490	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			64,444,483	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			307,391,180	6.00
7.00	Medicaid cost (line 1 times line 6)			61,014,075	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	19.00
			Uninsured patients	Insured patients	Total (col. 1 + col. 2)
			1.00	2.00	3.00
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	13,055,027	1,276,664	14,331,691	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,591,292	1,276,664	3,867,956	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,591,292	1,276,664	3,867,956	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)			10,117,328	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			232,858	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			358,243	27.01
28.00	Non-Medicare bad debt expense (see instructions)			9,759,085	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,062,466	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			5,930,422	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,930,422	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet A Date/Time Prepared: 11/28/2018 3:54 pm
Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)
	1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT		2,216,445	2,216,445	3,839,859	6,056,304
2.00 00200 CAP REL COSTS-MVBLE EQUIP		6,505,842	6,505,842	86,691	6,592,533
3.00 00300 OTHER CAP REL COSTS		0	0	0	0
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-69,142	-817,591	-886,733	11,490,253	10,603,520
5.00 00500 ADMIN STRATIVE & GENERAL	4,943,354	38,255,450	43,198,804	-1,401,390	41,797,414
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700 OPERATION OF PLANT	1,281,860	4,453,306	5,735,166	-206,411	5,528,755
8.00 00800 LAUNDRY & LINEN SERVICE	56,686	407,207	463,893	-27,604	436,289
9.00 00900 HOUSEKEEPING	933,550	1,029,186	1,962,736	-417,565	1,545,171
10.00 01000 DIETARY	991,044	1,916,675	2,907,719	-2,077,239	830,480
11.00 01100 CAFETERIA	0	0	0	1,620,909	1,620,909
13.00 01300 NURSING ADMINISTRATION	896,670	276,808	1,173,478	-200,274	973,204
14.00 01400 CENTRAL SERVICES & SUPPLY	166,482	209,038	375,520	-303,600	71,920
15.00 01500 PHARMACY	2,023,309	5,002,905	7,026,214	-4,700,063	2,326,151
16.00 01600 MEDICAL RECORDS & LIBRARY	23,196	47,321	70,517	-17,486	53,031
17.00 01700 SOCIAL SERVICE	0	0	0	0	0
20.00 02000 NURSING SCHOOL	0	0	0	0	0
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,290,676	1,290,676
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	2,258,737	554,038	2,812,775	-1,725,134	1,087,641
23.00 02300 PARAMED ED PRGM-PHARMACY	90,859	339,278	430,137	-18,743	411,394
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	14,090,020	8,354,740	22,444,760	-4,359,572	18,085,188
31.00 03100 INTENSIVE CARE UNIT	2,312,905	790,062	3,102,967	-671,782	2,431,185
40.00 04000 SUBPROVIDER - I PF	731,168	218,793	949,961	-189,103	760,858
41.00 04100 SUBPROVIDER - I RF	578,830	162,736	741,566	-140,319	601,247
43.00 04300 NURSERY	341,520	292,059	633,579	-94,954	538,625
44.00 04400 SKILLED NURSING FACILITY	1,271,439	436,396	1,707,835	-341,181	1,366,654
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	3,253,486	8,154,989	11,408,475	-7,213,835	4,194,640
51.00 05100 RECOVERY ROOM	428,899	103,094	531,993	-96,695	435,298
52.00 05200 DELIVERY ROOM & LABOR ROOM	809,286	85,367	894,653	-124,033	770,620
53.00 05300 ANESTHESIOLOGY	46,227	1,014,253	1,060,480	-155,591	904,889
54.00 05400 RADIOLOGY-DIAGNOSTIC	1,802,634	731,777	2,534,411	-677,138	1,857,273
54.01 03190 OUTPATIENT ONCOLOGY	752,685	4,200,949	4,953,634	-289,846	4,663,788
55.00 05500 RADIOLOGY-THERAPEUTIC	102,790	132,782	235,572	-25,386	210,186
57.00 05700 CT SCAN	328,726	103,929	432,655	-103,928	328,727
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	149,828	150,252	300,080	-43,600	256,480
59.00 05900 CARDIAC CATHETERIZATION	280,421	632,154	912,575	-605,409	307,166
60.00 06000 LABORATORY	0	5,391,025	5,391,025	-35,736	5,355,289
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	23,695	2,426	26,121	-31	26,090
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	8,792	8,792	-4,270	4,522
65.00 06500 RESPIRATORY THERAPY	868,616	428,351	1,296,967	-353,676	943,291
66.00 06600 PHYSICAL THERAPY	1,378,889	312,866	1,691,755	-297,733	1,394,022
67.00 06700 OCCUPATIONAL THERAPY	534,650	114,683	649,333	-113,653	535,680
68.00 06800 SPEECH PATHOLOGY	151,396	29,408	180,804	-29,134	151,670
69.00 06900 ELECTROCARDIOLOGY	511,606	236,082	747,688	-129,173	618,515
70.00 07000 ELECTROENCEPHALOGRAPHY	133,108	328,235	461,343	-36,416	424,927
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,169,984	5,169,984
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,596,430	3,596,430
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	4,259,986	4,259,986
74.00 07400 RENAL DIALYSIS	0	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	2,368,748	2,368,748	-57,279	2,311,469
76.01 03950 IP RENAL DIALYSIS	272,389	152,483	424,872	-56,161	368,711
76.97 07697 CARDIAC REHABILITATION	72,997	15,196	88,193	-15,127	73,066
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99 07699 LI THOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	491,809	513,217	1,005,026	-101,562	903,464
91.00 09100 EMERGENCY	3,438,665	2,233,132	5,671,797	-1,166,127	4,505,670
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE		2,623,064	2,623,064	-2,623,064	0
114.00 11400 UTILIZATION REVIEW-SNF		0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	48,755,289	100,717,948	149,473,237	107,765
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0
192.00 19200 PHYSICIANS' PRIVATE OFFICES	14,469	22,334	36,803	-150,020	-113,217
193.00 19300 NONPAID WORKERS	0	0	0	0	0
194.00 07950 CONVENT	0	0	0	42,255	42,255
194.01 07951 OUTPATIENT PHARMACY	0	740,543	740,543	0	740,543

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018	Worksheet A Date/Time Prepared: 11/28/2018 3:54 pm		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
194.02	07952 FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00	TOTAL (SUM OF LINES 118 through 199)	48,769,758	101,480,825	150,250,583	0	150,250,583	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0180

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

Worksheet A
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,019,736	4,036,568	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	427,911	7,020,444	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-17,630,897	-7,027,377	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,459,388	69,256,802	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	5,528,755	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	436,289	8.00
9.00	00900	HOUSEKEEPING	0	1,545,171	9.00
10.00	01000	DIETARY	0	830,480	10.00
11.00	01100	CAFETERIA	-587,335	1,033,574	11.00
13.00	01300	NURSING ADMINISTRATION	-680	972,524	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	71,920	14.00
15.00	01500	PHARMACY	-2	2,326,149	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,146,994	1,200,025	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,290,676	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,087,641	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	0	411,394	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-81,040	18,004,148	30.00
31.00	03100	INTENSIVE CARE UNIT	23,615	2,454,800	31.00
40.00	04000	SUBPROVIDER - I PF	-23,642	737,216	40.00
41.00	04100	SUBPROVIDER - I RF	-15,000	586,247	41.00
43.00	04300	NURSERY	-180,000	358,625	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,366,654	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-455,988	3,738,652	50.00
51.00	05100	RECOVERY ROOM	0	435,298	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,758	804,378	52.00
53.00	05300	ANESTHESIOLOGY	-793,403	111,486	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,285	1,855,988	54.00
54.01	03190	OUTPATIENT ONCOLOGY	-142,138	4,521,650	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	210,186	55.00
57.00	05700	CT SCAN	0	328,727	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	256,480	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	307,166	59.00
60.00	06000	LABORATORY	-20,988	5,334,301	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	26,090	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,522	63.00
65.00	06500	RESPIRATORY THERAPY	-7,992	935,299	65.00
66.00	06600	PHYSICAL THERAPY	0	1,394,022	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	535,680	67.00
68.00	06800	SPEECH PATHOLOGY	0	151,670	68.00
69.00	06900	ELECTROCARDIOLOGY	-57,122	561,393	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-286,784	138,143	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,169,984	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,596,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,259,986	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	-63,018	2,248,451	76.00
76.01	03950	IP RENAL DIALYSIS	0	368,711	76.01
76.97	07697	CARDIAC REHABILITATION	-1,924	71,142	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-255,156	648,308	90.00
91.00	09100	EMERGENCY	-572,469	3,933,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,895,067	155,476,069	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	-113,217	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	CONVENT	0	42,255	194.00
194.01	07951	OUTPATIENT PHARMACY	0	740,543	194.01
194.02	07952	FUND DEVELOPMENT	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	194.03

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0180

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

Worksheet A
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
200.00	6.00	7.00		
TOTAL (SUM OF LINES 118 through 199)	5,895,067	156,145,650		200.00

RECLASSIFICATIONS

Provider CCN: 14-0180

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

Worksheet A-6
Date/Time Prepared:
11/28/2018 3:54 pm

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,672,572	1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	817,741	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
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
40.00		0.00	0	0	40.00
TOTALS			0	11,490,313	
B - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,259,986	1.00
TOTALS			0	4,259,986	
C - SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,169,984	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
30.00		0.00	0	0	30.00

RECLASSIFICATIONS

Provider CCN: 14-0180

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

Worksheet A-6
Date/Time Prepared:
11/28/2018 3:54 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
TOTALS			0	5,169,984	
D - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,596,430	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
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
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
TOTALS			0	3,596,430	
E - BUILDING INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	51,577	1.00
TOTALS			0	51,577	
F - MORTGAGE INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,623,064	1.00
TOTALS			0	2,623,064	
G - DEPRECIATION1					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,165,218	1.00
2.00	SKILLED NURSING FACILITY	44.00	0	594	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
35.00		0.00	0	0	35.00
36.00		0.00	0	0	36.00
37.00		0.00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0.00	0	0	39.00
TOTALS			0	1,165,812	
H - DEPRECIATION2					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	86,691	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

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
	TOTALS		0	86,691		
I - PHONE						
1.00	OPERATION OF PLANT	7.00	0	117,204		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	117,204		
J - CAFETERIA						
1.00	CAFETERIA	11.00	552,458	1,068,451		1.00
	TOTALS		552,458	1,068,451		
K - INTERNS RESIDENTS						
1.00	I&R SERVICES-SALARY & FRINGES	21.00	1,290,676	0		1.00
	APPRV					
	TOTALS		1,290,676	0		
L - CONVENT MAINT						
1.00	CONVENT	194.00	11,856	30,399		1.00
	TOTALS		11,856	30,399		
M - RECLASS EHW SALARY ACCRUAL						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	69,142	0		1.00
	TOTALS		69,142	0		
500.00	Grand Total: Increases		1,924,132	29,659,911		500.00

RECLASSIFICATIONS

Provider CCN: 14-0180

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

Worksheet A-6
Date/Time Prepared:
11/28/2018 3:54 pm

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS						
1.00		0.00	0	0	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1,173,977	0	2.00
3.00	OPERATION OF PLANT	7.00	0	276,720	0	3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	27,501	0	4.00
5.00	HOUSEKEEPING	9.00	0	415,106	0	5.00
6.00	DIETARY	10.00	0	449,936	0	6.00
7.00	NURSING ADMINISTRATION	13.00	0	188,663	0	7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	57,722	0	8.00
9.00	PHARMACY	15.00	0	413,164	0	9.00
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	7,309	0	10.00
11.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	434,249	0	11.00
12.00	PARAMED ED PRGM-PHARMACY	23.00	0	18,743	0	12.00
13.00	ADULTS & PEDIATRICS	30.00	0	3,470,975	0	13.00
14.00	INTENSIVE CARE UNIT	31.00	0	446,592	0	14.00
15.00	SUBPROVIDER - IPF	40.00	0	189,103	0	15.00
16.00	SUBPROVIDER - IRF	41.00	0	126,723	0	16.00
17.00	NURSERY	43.00	0	74,368	0	17.00
18.00	SKILLED NURSING FACILITY	44.00	0	299,960	0	18.00
19.00	OPERATING ROOM	50.00	0	725,340	0	19.00
20.00	RECOVERY ROOM	51.00	0	86,589	0	20.00
21.00	DELIVERY ROOM & LABOR ROOM	52.00	0	119,183	0	21.00
22.00	ANESTHESIOLOGY	53.00	0	11,469	0	22.00
23.00	RADIOLOGY-DIAGNOSTIC	54.00	0	426,167	0	23.00
24.00	RADIOLOGY-DIAGNOSTIC	54.00	0	156,622	0	24.00
25.00	RADIOLOGY-THERAPEUTIC	55.00	0	23,275	0	25.00
26.00	CT SCAN	57.00	0	73,877	0	26.00
27.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	29,164	0	27.00
28.00	CARDIAC CATHETERIZATION	59.00	0	56,863	0	28.00
29.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	2,396	0	29.00
30.00	RESPIRATORY THERAPY	65.00	0	199,055	0	30.00
31.00	PHYSICAL THERAPY	66.00	0	292,128	0	31.00
32.00	OCCUPATIONAL THERAPY	67.00	0	109,269	0	32.00
33.00	SPEECH PATHOLOGY	68.00	0	29,097	0	33.00
34.00	ELECTROCARDIOLOGY	69.00	0	117,144	0	34.00
35.00	ELECTROENCEPHALOGRAPHY	70.00	0	33,069	0	35.00
36.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	57,279	0	36.00
37.00	CARDIAC REHABILITATION	76.97	0	14,437	0	37.00
38.00	CLINIC	90.00	0	84,592	0	38.00
39.00	EMERGENCY	91.00	0	768,178	0	39.00
40.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,309	0	40.00
	TOTALS			11,490,313		
B - DRUGS						
1.00	PHARMACY	15.00	0	4,259,986	0	1.00
	TOTALS			4,259,986		
C - SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	49,298	0	1.00
2.00	PHARMACY	15.00	0	21,569	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,449	0	3.00
6.00	ADULTS & PEDIATRICS	30.00	0	626,293	0	6.00
7.00	INTENSIVE CARE UNIT	31.00	0	189,003	0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	9,708	0	8.00
9.00	NURSERY	43.00	0	20,586	0	9.00
10.00	SKILLED NURSING FACILITY	44.00	0	40,588	0	10.00
11.00	OPERATING ROOM	50.00	0	3,213,496	0	11.00
12.00	RECOVERY ROOM	51.00	0	9,091	0	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4,850	0	13.00
14.00	ANESTHESIOLOGY	53.00	0	131,276	0	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	50,201	0	15.00
16.00	OUTPATIENT ONCOLOGY	54.01	0	13,422	0	16.00
17.00	RADIOLOGY-THERAPEUTIC	55.00	0	1,839	0	17.00
18.00	CT SCAN	57.00	0	30,051	0	18.00
19.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	10,546	0	19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	285,075	0	20.00
21.00	LABORATORY	60.00	0	26,883	0	21.00
22.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	1,537	0	22.00
23.00	RESPIRATORY THERAPY	65.00	0	58,056	0	23.00
24.00	PHYSICAL THERAPY	66.00	0	2,422	0	24.00

RECLASSIFICATIONS

Provider CCN: 14-0180

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

Worksheet A-6
Date/Time Prepared:
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Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
25.00	OCCUPATIONAL THERAPY	67.00	0	1,487	0	25.00	
26.00	ELECTROCARDIOLOGY	69.00	0	5,548	0	26.00	
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,701	0	27.00	
28.00	IP RENAL DIALYSIS	76.01	0	48,064	0	28.00	
30.00	CARDIAC REHABILITATION	76.97	0	690	0	30.00	
31.00	CLINIC	90.00	0	4,713	0	31.00	
32.00	EMERGENCY	91.00	0	304,542	0	32.00	
	TOTALS		0	5,169,984			
D - IMPLANTS							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	19,825	0	1.00	
2.00	ADULTS & PEDIATRICS	30.00	0	197,677	0	2.00	
3.00	INTENSIVE CARE UNIT	31.00	0	21,348	0	3.00	
4.00	SUBPROVIDER - IRF	41.00	0	12	0	4.00	
6.00	SKILLED NURSING FACILITY	44.00	0	669	0	6.00	
7.00	OPERATING ROOM	50.00	0	2,986,535	0	7.00	
8.00	RECOVERY ROOM	51.00	0	962	0	8.00	
10.00	ANESTHESIOLOGY	53.00	0	11,059	0	10.00	
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,705	0	11.00	
12.00	OUTPATIENT ONCOLOGY	54.01	0	2,640	0	12.00	
14.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	3,546	0	14.00	
15.00	CARDIAC CATHETERIZATION	59.00	0	262,443	0	15.00	
16.00	PHYSICAL THERAPY	66.00	0	96	0	16.00	
18.00	ELECTROCARDIOLOGY	69.00	0	275	0	18.00	
19.00	IP RENAL DIALYSIS	76.01	0	7,999	0	19.00	
20.00	CLINIC	90.00	0	33	0	20.00	
21.00	EMERGENCY	91.00	0	71,606	0	21.00	
	TOTALS		0	3,596,430			
E - BUILDING INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51,577	12	1.00	
	TOTALS		0	51,577			
F - MORTGAGE INTEREST							
1.00	INTEREST EXPENSE	113.00	0	2,623,064	11	1.00	
	TOTALS		0	2,623,064			
G - DEPRECIATION							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	60	9	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	47,749	9	2.00	
3.00	OPERATION OF PLANT	7.00	0	3,207	9	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	103	9	4.00	
5.00	HOUSEKEEPING	9.00	0	13	9	5.00	
6.00	DIETARY	10.00	0	5,346	9	6.00	
7.00	NURSING ADMINISTRATION	13.00	0	7,249	9	7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	173,177	9	8.00	
9.00	PHARMACY	15.00	0	4,467	9	9.00	
10.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,728	9	10.00	
11.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	209	9	11.00	
12.00	ADULTS & PEDIATRICS	30.00	0	43,801	9	12.00	
13.00	INTENSIVE CARE UNIT	31.00	0	2,662	9	13.00	
14.00	SUBPROVIDER - IRF	41.00	0	3,876	9	14.00	
16.00	OPERATING ROOM	50.00	0	282,351	9	16.00	
17.00	RECOVERY ROOM	51.00	0	53	9	17.00	
18.00	ANESTHESIOLOGY	53.00	0	150	9	18.00	
19.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,865	9	19.00	
20.00	OUTPATIENT ONCOLOGY	54.01	0	1,309	9	20.00	
21.00	RADIOLOGY-THERAPEUTIC	55.00	0	272	9	21.00	
22.00	CARDIAC CATHETERIZATION	59.00	0	1,028	9	22.00	
23.00	LABORATORY	60.00	0	8,853	9	23.00	
24.00	BLOOD CLOTTING FOR HEMOPHILIACS	62.30	0	31	9	24.00	
25.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	337	9	25.00	
26.00	RESPIRATORY THERAPY	65.00	0	90,472	9	26.00	
27.00	PHYSICAL THERAPY	66.00	0	2,715	9	27.00	
28.00	OCCUPATIONAL THERAPY	67.00	0	1,100	9	28.00	
29.00	SPEECH PATHOLOGY	68.00	0	37	9	29.00	
30.00	ELECTROCARDIOLOGY	69.00	0	6,206	9	30.00	
31.00	ELECTROENCEPHALOGRAPHY	70.00	0	646	9	31.00	
32.00	IP RENAL DIALYSIS	76.01	0	98	9	32.00	
33.00	CLINIC	90.00	0	12,224	9	33.00	
34.00	EMERGENCY	91.00	0	10,537	9	34.00	
35.00	OUTPATIENT ONCOLOGY	54.01	0	259,377	0	35.00	
36.00	RADIOLOGY-DIAGNOSTIC	54.00	0	23,558	0	36.00	
37.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	68,705	0	37.00	

RECLASSIFICATIONS

Provider CCN: 14-0180

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

Worksheet A-6
Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
38.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	76,781	0		38.00
39.00	OUTPATIENT ONCOLOGY	54.01	0	12,460	0		39.00
	TOTALS		0	1,165,812			
H - DEPRECIATION2							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,156	9		1.00
2.00	OPERATION OF PLANT	7.00	0	1,433	9		2.00
3.00	HOUSEKEEPING	9.00	0	2,446	9		3.00
4.00	NURSING ADMINISTRATION	13.00	0	4,362	9		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,578	9		5.00
6.00	PHARMACY	15.00	0	877	9		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	20,826	9		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	12,177	9		8.00
9.00	SKILLED NURSING FACILITY	44.00	0	558	9		9.00
10.00	OPERATING ROOM	50.00	0	6,113	9		10.00
11.00	ANESTHESIOLOGY	53.00	0	1,637	9		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10	9		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10	9		13.00
14.00	OUTPATIENT ONCOLOGY	54.01	0	319	9		14.00
15.00	OUTPATIENT ONCOLOGY	54.01	0	319	9		15.00
16.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	344	9		16.00
17.00	RESPIRATORY THERAPY	65.00	0	6,093	9		17.00
18.00	PHYSICAL THERAPY	66.00	0	372	9		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	1,797	9		19.00
20.00	EMERGENCY	91.00	0	11,264	9		20.00
	TOTALS		0	86,691			
I - PHONE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	115,931	0		1.00
2.00	DIETARY	10.00	0	1,048	0		2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	225	0		3.00
	TOTALS		0	117,204			
J - CAFETERIA							
1.00	DIETARY	10.00	552,458	1,068,451	0		1.00
	TOTALS		552,458	1,068,451			
K - INTERNS RESIDENTS							
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	1,290,676	0	0		1.00
	TOTALS		1,290,676	0			
L - CONVENT MAINT							
1.00	OPERATION OF PLANT	7.00	11,856	30,399	0		1.00
	TOTALS		11,856	30,399			
M - RECLASS EHW SALARY ACCRUAL							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	69,142	0		1.00
	TOTALS		0	69,142			
500.00	Grand Total: Decreases		1,854,990	29,729,053			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0180

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

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,370,865	29,639,135	0	29,639,135	0	1.00
2.00	Land Improvements	1,198,805	0	0	0	926,055	2.00
3.00	Buildings and Fixtures	129,440,640	0	0	0	15,760,376	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	89,364,457	0	0	0	62,935,875	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	225,374,767	29,639,135	0	29,639,135	79,622,306	8.00
9.00	Reconciling Items	73,884	0	0	0	73,884	9.00
10.00	Total (line 8 minus line 9)	225,300,883	29,639,135	0	29,639,135	79,548,422	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	35,010,000	0				1.00
2.00	Land Improvements	272,750	0				2.00
3.00	Buildings and Fixtures	113,680,264	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	26,428,582	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	175,391,596	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	175,391,596	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0180

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

Worksheet A-7
Part II
Date/Time Prepared:
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Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,216,445	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,505,842	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	8,722,287	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,216,445				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	6,505,842				2.00
3.00	Total (sum of lines 1-2)	0	8,722,287				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet A-7 Part III Date/Time Prepared: 11/28/2018 3:54 pm
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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	148,963,014	0	148,963,014	0.849317	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	26,428,582	0	26,428,582	0.150683	0	2.00
3.00	Total (sum of lines 1-2)	175,391,596	0	175,391,596	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col.s. 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	2,818,138	-424,509	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,020,444	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,838,582	-424,509	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.s. 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	4,214,242	51,577	0	-2,622,880	4,036,568	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	7,020,444	2.00
3.00	Total (sum of lines 1-2)	4,214,242	51,577	0	-2,622,880	11,057,012	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0180

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

Worksheet A-8

Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,110,823				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	10,962,303				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-587,335	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			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	A	-588,795	CAP REL COSTS-BLDG & FIXT		1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	401,720	CAP REL COSTS-MVBLE EQUIP		2.00	9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				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 MISC REV OFFSET	B		0	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	33.00
34.00 MISC REV OFFSET	B	-680,652	ADMINISTRATIVE & GENERAL		5.00	0	34.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0180

Period:
From 01/01/2018
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		
36.00 MISC REV OFFSET	B	-680	NURSING ADMINISTRATION	13.00	0	36.00
37.00 MISC REV OFFSET	B	-2	PHARMACY	15.00	0	37.00
38.00 MISC REV OFFSET	B	-126,820	OPERATING ROOM	50.00	0	38.00
39.00 MISC REV OFFSET	B	-1,285	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
41.00 OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	41.00
43.00 OTHER ADJUSTMENTS (SPECIFY) (3)	B	0		0.00	0	43.00
44.00 MISC REV OFFSET	B	-35,891	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	44.00
45.00 MISC REV OFFSET	B	-1,924	CARDIAC REHABILITATION	76.97	0	45.00
46.00 MISC REV OFFSET	B	-211	CLINIC	90.00	0	46.00
47.00 COST OFFSET- CONTRIBUTIONS	A	-305,236	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00 OFFSET ALCOHOL EXPENSE	A	-1,000	ADMINISTRATIVE & GENERAL	5.00	0	48.00
48.01 COST OFFSET- CONTRIBUTIONS	A	-27,127	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	48.01
48.02 INCOME TAX	A	-1,175	ADMINISTRATIVE & GENERAL	5.00	0	48.02
48.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	48.03
48.04 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	48.04
48.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	48.05
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		5,895,067				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: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet A-8-1 Date/Time Prepared: 11/28/2018 3:54 pm
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Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	-2,622,880	0
2.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	1,591,178	0
3.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	-424,509	0
4.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	26,191	0
4.01	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	25,270	0
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	190,930	17,729,234
4.03	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	21,762,585	0
4.04	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	3,346,742	0
4.05	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	2,226,111	0
4.06	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	-239,541	0
4.07	16.00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	1,146,994	0
4.08	31.00	INTENSIVE CARE UNIT	HOME OFFICE	295,844	0
4.09	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,351,554	0
4.10	0.00			0	0
4.11	0.00			0	0
4.12	60.00	LABORATORY	ALVERNO	4,941,971	4,926,903
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			33,618,440	22,656,137

* 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		100.00	PRESENCE HEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0180

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2018 3:54 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-2,622,880	14		1.00
2.00	1,591,178	11		2.00
3.00	-424,509	10		3.00
4.00	26,191	9		4.00
4.01	25,270	9		4.01
4.02	-17,538,304	0		4.02
4.03	21,762,585	0		4.03
4.04	3,346,742	0		4.04
4.05	2,226,111	0		4.05
4.06	-239,541	0		4.06
4.07	1,146,994	0		4.07
4.08	295,844	0		4.08
4.09	1,351,554	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	15,068	0		4.12
5.00	10,962,303			5.00

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

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

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

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

6.00	SOLE CORPORATE MEMBER		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: 14-0180

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2018 3:54 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	81,040	81,040	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	272,229	272,229	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	15,000	15,000	0	0	0	3.00
4.00	43.00	NURSERY	180,000	180,000	0	0	0	4.00
5.00	50.00	OPERATING ROOM	329,168	329,168	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	-33,758	-33,758	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	793,403	793,403	0	0	0	7.00
8.00	54.01	OUTPATIENT ONCOLOGY	142,138	142,138	0	0	0	8.00
9.00	60.00	LABORATORY	36,056	36,056	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	7,992	7,992	0	0	0	10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	57,122	57,122	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	286,784	286,784	0	0	0	13.00
14.00	90.00	CLINIC	254,945	254,945	0	0	0	14.00
15.00	91.00	EMERGENCY	572,469	572,469	0	0	0	15.00
16.00	40.00	SUBPROVIDER - IPF	23,642	23,642	0	0	0	16.00
17.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	92,593	92,593	0	0	0	17.00
200.00			3,110,823	3,110,823	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	3.00
4.00	43.00	NURSERY	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.01	OUTPATIENT ONCOLOGY	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	11.00
12.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	13.00
14.00	90.00	CLINIC	0	0	0	0	0	14.00
15.00	91.00	EMERGENCY	0	0	0	0	0	15.00
16.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	16.00
17.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	17.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	81,040		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	0	0	272,229		2.00
3.00	41.00	SUBPROVIDER - IRF	0	0	0	15,000		3.00
4.00	43.00	NURSERY	0	0	0	180,000		4.00
5.00	50.00	OPERATING ROOM	0	0	0	329,168		5.00
6.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	-33,758		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	793,403		7.00
8.00	54.01	OUTPATIENT ONCOLOGY	0	0	0	142,138		8.00
9.00	60.00	LABORATORY	0	0	0	36,056		9.00
10.00	65.00	RESPIRATORY THERAPY	0	0	0	7,992		10.00
11.00	66.00	PHYSICAL THERAPY	0	0	0	0		11.00
12.00	69.00	ELECTROCARDIOLOGY	0	0	0	57,122		12.00
13.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	286,784		13.00
14.00	90.00	CLINIC	0	0	0	254,945		14.00
15.00	91.00	EMERGENCY	0	0	0	572,469		15.00
16.00	40.00	SUBPROVIDER - IPF	0	0	0	23,642		16.00
17.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	92,593		17.00
200.00			0	0	0	3,110,823		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

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	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,036,568	4,036,568			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,020,444		7,020,444		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	-7,027,377	27,900	48,524	-6,950,953	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	69,256,802	239,898	417,233	0	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	5,528,755	490,143	852,463	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	436,289	16,862	29,327	0	8.00
9.00 00900	HOUSEKEEPING	1,545,171	50,719	88,210	0	9.00
10.00 01000	DIETARY	830,480	100,691	175,122	0	10.00
11.00 01100	CAFETERIA	1,033,574	15,060	26,192	0	11.00
13.00 01300	NURSING ADMINISTRATION	972,524	77,194	134,256	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	71,920	75,668	131,603	0	14.00
15.00 01500	PHARMACY	2,326,149	27,290	47,463	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,200,025	47,399	82,437	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	1,290,676	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,087,641	8,698	15,128	0	22.00
23.00 02300	PARAMED ED PRGM-PHARMACY	411,394	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	18,004,148	778,126	1,353,327	0	30.00
31.00 03100	INTENSIVE CARE UNIT	2,454,800	40,459	70,367	0	31.00
40.00 04000	SUBPROVIDER - I/PF	737,216	19,495	33,906	0	40.00
41.00 04100	SUBPROVIDER - I/RF	586,247	33,246	57,823	0	41.00
43.00 04300	NURSERY	358,625	7,430	12,922	0	43.00
44.00 04400	SKILLED NURSING FACILITY	1,366,654	37,304	64,880	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	3,738,652	213,993	372,178	0	50.00
51.00 05100	RECOVERY ROOM	435,298	14,024	24,391	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	804,378	98,134	170,675	0	52.00
53.00 05300	ANESTHESIOLOGY	111,486	2,063	3,588	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,855,988	84,467	146,906	0	54.00
54.01 03190	OUTPATIENT ONCOLOGY	4,521,650	907	1,578	0	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	210,186	5,178	9,005	0	55.00
57.00 05700	CT SCAN	328,727	8,654	15,051	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	256,480	3,187	5,543	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	307,166	22,040	38,332	0	59.00
60.00 06000	LABORATORY	5,334,301	75,660	131,590	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	26,090	0	0	0	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	4,522	6,282	10,925	0	63.00
65.00 06500	RESPIRATORY THERAPY	935,299	4,544	7,902	0	65.00
66.00 06600	PHYSICAL THERAPY	1,394,022	35,871	62,388	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	535,680	3,861	6,716	0	67.00
68.00 06800	SPEECH PATHOLOGY	151,670	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	561,393	31,745	55,212	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	138,143	8,606	14,967	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,169,984	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,596,430	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4,259,986	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,248,451	48,447	84,259	0	76.00
76.01 03950	I/P RENAL DIALYSIS	368,711	2,436	4,237	0	76.01
76.97 07697	CARDIAC REHABILITATION	71,142	14,165	24,636	0	76.97
76.98 07698	HYPERBARIIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	648,308	105,359	183,241	0	90.00
91.00 09100	EMERGENCY	3,933,201	636,961	1,107,809	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	155,476,069	3,520,166	6,122,312	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,741	4,768	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	-113,217	477,082	829,747	0	192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	193.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

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	
194.00 07950 CONVENT	42,255	33,283	57,885	0	133,423	194.00
194.01 07951 OUTPATIENT PHARMACY	740,543	2,196	3,819	0	746,558	194.01
194.02 07952 FUND DEVELOPMENT	0	1,100	1,913	0	3,013	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers		0	0	-6,950,953	-6,950,953	201.00
202.00 TOTAL (sum lines 118 through 201)	156,145,650	4,036,568	7,020,444	-6,950,953	156,145,650	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/28/2018 3:54 pm		
Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
			5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	69,913,933				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	5,155,507	0	12,026,868		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	361,998	0	61,854	906,330	8.00
9.00	00900	HOUSEKEEPING	1,263,562	0	186,049	46,778	3,180,489
10.00	01000	DIETARY	830,039	0	369,360	0	99,732
11.00	01100	CAFETERIA	806,430	0	55,243	0	14,917
13.00	01300	NURSING ADMINISTRATION	888,323	0	283,167	0	76,459
14.00	01400	CENTRAL SERVICES & SUPPLY	209,474	0	277,572	1,263	74,948
15.00	01500	PHARMACY	1,801,370	0	100,107	0	27,030
16.00	01600	MEDICAL RECORDS & LIBRARY	997,780	0	173,873	0	46,948
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	968,380	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	833,921	0	31,906	0	8,615
23.00	02300	PARAMED ED PRGM-PHARMACY	308,664	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,107,519	0	2,854,374	301,573	770,725
31.00	03100	INTENSIVE CARE UNIT	1,924,961	0	148,415	24,895	40,074
40.00	04000	SUBPROVIDER - IPF	593,191	0	71,513	40,602	19,310
41.00	04100	SUBPROVIDER - IRF	508,183	0	121,957	49,183	32,930
43.00	04300	NURSERY	284,342	0	27,254	0	7,359
44.00	04400	SKILLED NURSING FACILITY	1,102,053	0	136,842	29,968	36,949
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,244,867	0	784,982	114,536	211,956
51.00	05100	RECOVERY ROOM	355,422	0	51,445	19,730	13,891
52.00	05200	DELIVERY ROOM & LABOR ROOM	805,200	0	359,981	8,706	97,200
53.00	05300	ANESTHESIOLOGY	87,887	0	7,568	0	2,043
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,566,124	0	309,846	68,448	83,663
54.01	03190	OUTPATIENT ONCOLOGY	3,394,409	0	3,328	8,378	898
55.00	05500	RADIOLOGY-THERAPEUTIC	168,342	0	18,994	0	5,129
57.00	05700	CT SCAN	264,426	0	31,744	0	8,571
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	198,984	0	11,691	0	3,157
59.00	05900	CARDIAC CATHETERIZATION	275,760	0	80,848	4,691	21,830
60.00	06000	LABORATORY	4,157,765	0	277,543	0	74,940
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	19,575	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	16,303	0	23,043	0	6,222
65.00	06500	RESPIRATORY THERAPY	711,083	0	16,667	0	4,500
66.00	06600	PHYSICAL THERAPY	1,119,642	0	131,586	24,984	35,530
67.00	06700	OCCUPATIONAL THERAPY	409,851	0	14,164	0	3,825
68.00	06800	SPEECH PATHOLOGY	113,796	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	486,450	0	116,450	12,464	31,443
70.00	07000	ELECTROENCEPHALOGRAPHY	121,334	0	31,568	0	8,524
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,878,982	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,698,362	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,196,221	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,786,556	0	177,716	0	47,986
76.01	03950	IP RENAL DIALYSIS	281,646	0	8,937	4,211	2,413
76.97	07697	CARDIAC REHABILITATION	82,489	0	51,960	215	14,030
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LI THOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	702,952	0	386,484	2,347	104,356
91.00	09100	EMERGENCY	4,260,119	0	2,336,540	142,601	630,899
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	68,350,244	0	10,132,571	905,573	2,669,002
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	5,634	0	10,056	0	2,715
192.00	19200	PHYSICIANS' PRIVATE OFFICES	895,554	0	1,750,064	757	472,542
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	CONVENT	100,106	0	122,089	0	32,966
194.01	07951	OUTPATIENT PHARMACY	560,134	0	8,054	0	2,175
194.02	07952	FUND DEVELOPMENT	2,261	0	4,034	0	1,089
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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

Worksheet B
Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	69,913,933	0	12,026,868	906,330	3,180,489	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part I Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	2,405,424					10.00
11.00	01100	CAFETERIA	0	1,951,416				11.00
13.00	01300	NURSING ADMINISTRATION	0	43,051	2,474,974			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,993	0	850,441		14.00
15.00	01500	PHARMACY	0	97,143	0	0	4,426,552	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,114	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	61,968	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	46,479	0	0	0	22.00
23.00	02300	PARAMED PRGM-PHARMACY	0	4,362	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,911,429	676,493	1,254,225	262,007	1,363,484	30.00
31.00	03100	INTENSIVE CARE UNIT	110,511	111,047	216,536	28,364	147,647	31.00
40.00	04000	SUBPROVIDER - IPF	107,559	35,105	60,396	10,437	54,329	40.00
41.00	04100	SUBPROVIDER - IRF	101,516	27,791	64,997	11,707	60,938	41.00
43.00	04300	NURSERY	0	16,397	37,264	15,761	82,043	43.00
44.00	04400	SKILLED NURSING FACILITY	174,409	61,044	69,441	8,226	42,818	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	156,206	251,148	53,723	279,653	50.00
51.00	05100	RECOVERY ROOM	0	20,592	43,933	10,475	54,527	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	38,855	21,353	7,105	36,986	52.00
53.00	05300	ANESTHESIOLOGY	0	2,219	0	11,131	57,941	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,548	3,323	17,517	91,184	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	36,138	48,442	46	240	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	4,935	0	104	542	55.00
57.00	05700	CT SCAN	0	15,783	1,356	22,137	115,232	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,194	0	4,233	22,034	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	13,464	11,435	12,233	63,680	59.00
60.00	06000	LABORATORY	0	0	0	86,399	449,749	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	1,138	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,894	20,268	63.00
65.00	06500	RESPIRATORY THERAPY	0	41,704	0	26,216	136,467	65.00
66.00	06600	PHYSICAL THERAPY	0	66,203	0	13,365	69,570	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,670	0	9,408	48,972	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,269	0	1,285	6,688	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,563	6,297	22,023	114,641	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,391	2,096	225	1,169	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	32,573	169,559	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	24,005	124,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	97,415	507,090	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	13	66	76.00
76.01	03950	IP RENAL DIALYSIS	0	13,078	0	9,833	51,185	76.01
76.97	07697	CARDIAC REHABILITATION	0	3,505	2,565	126	656	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	23,613	26,730	31	164	90.00
91.00	09100	EMERGENCY	0	165,097	351,419	48,424	252,072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,405,424	1,950,152	2,472,956	850,441	4,426,552	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	695	2,018	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	569	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

Period:
From 01/01/2018
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
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)	2,405,424	1,951,416	2,474,974	850,441	4,426,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
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	2,549,576					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
20.00 02000 NURSING SCHOOL	0	0	0			20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		2,321,024		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			2,032,388	22.00
23.00 02300 PARAMED ED PRGM-PHARMACY	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,966,797	0	0	2,118,338	1,854,907	30.00
31.00 03100 INTENSIVE CARE UNIT	113,712	0	0	122,473	107,243	31.00
40.00 04000 SUBPROVIDER - I PF	110,675	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I RF	104,457	0	0	0	0	41.00
43.00 04300 NURSERY	74,474	0	0	80,213	70,238	43.00
44.00 04400 SKILLED NURSING FACILITY	179,461	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01 03950 I P RENAL DIALYSIS	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2,549,576	0	0	2,321,024	2,032,388	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
194.00 07950 CONVENT	0	0	0	0	0	194.00
194.01 07951 OUTPATIENT PHARMACY	0	0	0	0	0	194.01

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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To 06/30/2018

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	INTERNS & RESIDENTS			
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV		
				16.00	17.00		20.00
194.02 07952 FUND DEVELOPMENT	0	0	0	0	0	0	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers	0	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2,549,576	0	0	2,321,024	2,032,388	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description		PARAMED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMED PRGM-PHARMACY	724,420			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	50,577,472	-3,973,245	46,604,227
31.00	03100	INTENSIVE CARE UNIT	0	5,661,504	-229,716	5,431,788
40.00	04000	SUBPROVIDER - I PF	0	1,893,734	0	1,893,734
41.00	04100	SUBPROVIDER - I RF	0	1,760,975	0	1,760,975
43.00	04300	NURSERY	0	1,074,322	-150,451	923,871
44.00	04400	SKILLED NURSING FACILITY	0	3,310,049	0	3,310,049
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	9,421,894	0	9,421,894
51.00	05100	RECOVERY ROOM	0	1,043,728	0	1,043,728
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,448,573	0	2,448,573
53.00	05300	ANESTHESIOLOGY	0	285,926	0	285,926
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,314,014	0	4,314,014
54.01	03190	OUTPATIENT ONCOLOGY	0	8,016,014	0	8,016,014
55.00	05500	RADIOLOGY-THERAPEUTIC	0	422,415	0	422,415
57.00	05700	CT SCAN	0	811,681	0	811,681
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	512,503	0	512,503
59.00	05900	CARDIAC CATHETERIZATION	0	851,479	0	851,479
60.00	06000	LABORATORY	0	10,587,947	0	10,587,947
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	46,803	0	46,803
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	91,459	0	91,459
65.00	06500	RESPIRATORY THERAPY	0	1,884,382	0	1,884,382
66.00	06600	PHYSICAL THERAPY	0	2,953,161	0	2,953,161
67.00	06700	OCCUPATIONAL THERAPY	0	1,058,147	0	1,058,147
68.00	06800	SPEECH PATHOLOGY	0	280,708	0	280,708
69.00	06900	ELECTROCARDIOLOGY	0	1,462,681	0	1,462,681
70.00	07000	ELECTROENCEPHALOGRAPHY	0	333,023	0	333,023
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,251,098	0	9,251,098
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,443,755	0	6,443,755
73.00	07300	DRUGS CHARGED TO PATIENTS	724,420	8,785,132	0	8,785,132
74.00	07400	RENAL DIALYSIS	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	4,393,494	0	4,393,494
76.01	03950	IP RENAL DIALYSIS	0	746,687	0	746,687
76.97	07697	CARDIAC REHABILITATION	0	265,489	0	265,489
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0
76.99	07699	LI THOTRI PSY	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	2,183,585	0	2,183,585
91.00	09100	EMERGENCY	0	13,865,142	0	13,865,142
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	724,420	157,038,976	-4,353,412	152,685,564
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	25,914	0	25,914
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,315,242	0	4,315,242
193.00	19300	NONPAID WORKERS	0	0	0	0
194.00	07950	CONVENT	0	389,153	0	389,153
194.01	07951	OUTPATIENT PHARMACY	0	1,316,921	0	1,316,921

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0180

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description		PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
194.02	07952 FUND DEVELOPMENT	0	10,397	0	10,397		194.02
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0		194.03
200.00	Cross Foot Adjustments	0	0	0	0		200.00
201.00	Negative Cost Centers	0	-6,950,953	0	-6,950,953		201.00
202.00	TOTAL (sum lines 118 through 201)	724,420	156,145,650	-4,353,412	151,792,238		202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm
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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			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	27,900	48,524	76,424	76,424 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	239,898	417,233	657,131	0 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	0	490,143	852,463	1,342,606	0 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	16,862	29,327	46,189	0 8.00
9.00 00900	HOUSEKEEPING	0	50,719	88,210	138,929	0 9.00
10.00 01000	DIETARY	0	100,691	175,122	275,813	0 10.00
11.00 01100	CAFETERIA	0	15,060	26,192	41,252	0 11.00
13.00 01300	NURSING ADMINISTRATION	0	77,194	134,256	211,450	0 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	75,668	131,603	207,271	0 14.00
15.00 01500	PHARMACY	0	27,290	47,463	74,753	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	47,399	82,437	129,836	0 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	8,698	15,128	23,826	0 22.00
23.00 02300	PARAMED ED PRGM-PHARMACY	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	778,126	1,353,327	2,131,453	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0	40,459	70,367	110,826	0 31.00
40.00 04000	SUBPROVIDER - IPF	0	19,495	33,906	53,401	0 40.00
41.00 04100	SUBPROVIDER - IRF	0	33,246	57,823	91,069	0 41.00
43.00 04300	NURSERY	0	7,430	12,922	20,352	0 43.00
44.00 04400	SKILLED NURSING FACILITY	0	37,304	64,880	102,184	0 44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	213,993	372,178	586,171	0 50.00
51.00 05100	RECOVERY ROOM	0	14,024	24,391	38,415	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	98,134	170,675	268,809	0 52.00
53.00 05300	ANESTHESIOLOGY	0	2,063	3,588	5,651	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	84,467	146,906	231,373	0 54.00
54.01 03190	OUTPATIENT ONCOLOGY	0	907	1,578	2,485	0 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	5,178	9,005	14,183	0 55.00
57.00 05700	CT SCAN	0	8,654	15,051	23,705	0 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	3,187	5,543	8,730	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	22,040	38,332	60,372	0 59.00
60.00 06000	LABORATORY	0	75,660	131,590	207,250	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	6,282	10,925	17,207	0 63.00
65.00 06500	RESPIRATORY THERAPY	0	4,544	7,902	12,446	0 65.00
66.00 06600	PHYSICAL THERAPY	0	35,871	62,388	98,259	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	3,861	6,716	10,577	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	31,745	55,212	86,957	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	8,606	14,967	23,573	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	48,447	84,259	132,706	0 76.00
76.01 03950	IP RENAL DIALYSIS	0	2,436	4,237	6,673	0 76.01
76.97 07697	CARDIAC REHABILITATION	0	14,165	24,636	38,801	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	105,359	183,241	288,600	0 90.00
91.00 09100	EMERGENCY	0	636,961	1,107,809	1,744,770	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	3,520,166	6,122,312	9,642,478	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	2,741	4,768	7,509	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	477,082	829,747	1,306,829	0 192.00
193.00 19300	NONPAID WORKERS	0	0	0	0	0 193.00
194.00 07950	CONVENT	0	33,283	57,885	91,168	0 194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

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

Worksheet B
Part II
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
194.01 07951 OUTPATIENT PHARMACY	0	2,196	3,819	6,015	0	194.01
194.02 07952 FUND DEVELOPMENT	0	1,100	1,913	3,013	0	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	76,424	201.00
202.00 TOTAL (sum lines 118 through 201)	0	4,036,568	7,020,444	11,057,012	76,424	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	657,131			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	48,457	0	1,391,063	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	3,402	0	7,154	56,745	8.00	
9.00	00900	HOUSEKEEPING	11,876	0	21,519	2,929	175,253	9.00
10.00	01000	DIETARY	7,802	0	42,721	0	5,496	10.00
11.00	01100	CAFETERIA	7,580	0	6,390	0	822	11.00
13.00	01300	NURSING ADMINISTRATION	8,349	0	32,752	0	4,213	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,969	0	32,105	79	4,130	14.00
15.00	01500	PHARMACY	16,931	0	11,579	0	1,489	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,378	0	20,111	0	2,587	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	9,102	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,838	0	3,690	0	475	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	2,901	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	142,006	0	330,145	18,882	42,467	30.00
31.00	03100	INTENSIVE CARE UNIT	18,093	0	17,166	1,559	2,208	31.00
40.00	04000	SUBPROVIDER - IPF	5,575	0	8,271	2,542	1,064	40.00
41.00	04100	SUBPROVIDER - IRF	4,776	0	14,106	3,079	1,815	41.00
43.00	04300	NURSERY	2,673	0	3,152	0	405	43.00
44.00	04400	SKILLED NURSING FACILITY	10,358	0	15,828	1,876	2,036	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	30,499	0	90,793	7,171	11,679	50.00
51.00	05100	RECOVERY ROOM	3,341	0	5,950	1,235	765	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,568	0	41,636	545	5,356	52.00
53.00	05300	ANESTHESIOLOGY	826	0	875	0	113	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,720	0	35,838	4,286	4,610	54.00
54.01	03190	OUTPATIENT ONCOLOGY	31,904	0	385	525	50	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,582	0	2,197	0	283	55.00
57.00	05700	CT SCAN	2,485	0	3,672	0	472	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,870	0	1,352	0	174	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,592	0	9,351	294	1,203	59.00
60.00	06000	LABORATORY	39,079	0	32,101	0	4,129	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	184	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	153	0	2,665	0	343	63.00
65.00	06500	RESPIRATORY THERAPY	6,683	0	1,928	0	248	65.00
66.00	06600	PHYSICAL THERAPY	10,524	0	15,220	1,564	1,958	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,852	0	1,638	0	211	67.00
68.00	06800	SPEECH PATHOLOGY	1,070	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,572	0	13,469	780	1,733	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,140	0	3,651	0	470	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	36,459	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,362	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,041	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	16,792	0	20,555	0	2,644	76.00
76.01	03950	IP RENAL DIALYSIS	2,647	0	1,034	264	133	76.01
76.97	07697	CARDIAC REHABILITATION	775	0	6,010	13	773	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,607	0	44,702	147	5,750	90.00
91.00	09100	EMERGENCY	40,041	0	270,251	8,928	34,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	642,434	0	1,171,962	56,698	147,068	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	53	0	1,163	0	150	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,417	0	202,418	47	26,038	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	941	0	14,121	0	1,817	194.00
194.01	07951	OUTPATIENT PHARMACY	5,265	0	932	0	120	194.01
194.02	07952	FUND DEVELOPMENT	21	0	467	0	60	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0180			Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
201.00	Negative Cost Centers	5.00	6.00	7.00	8.00	9.00	0	201.00
202.00	TOTAL (sum lines 118 through 201)	657,131	0	1,391,063	56,745	175,253	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	331,832					10.00
11.00	01100	CAFETERIA	0	56,044				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,237	258,001			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	230	0	245,784		14.00
15.00	01500	PHARMACY	0	2,790	0	0	107,542	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,780	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,335	0	0	0	22.00
23.00	02300	PARAMED PRGM-PHARMACY	0	125	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	263,685	19,424	130,746	75,696	33,183	30.00
31.00	03100	INTENSIVE CARE UNIT	15,245	3,189	22,573	8,199	3,584	31.00
40.00	04000	SUBPROVIDER - IPF	14,838	1,008	6,296	3,017	1,319	40.00
41.00	04100	SUBPROVIDER - IRF	14,004	798	6,776	3,384	1,479	41.00
43.00	04300	NURSERY	0	471	3,885	4,556	1,992	43.00
44.00	04400	SKILLED NURSING FACILITY	24,060	1,753	7,239	2,378	1,039	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,487	26,181	15,529	6,789	50.00
51.00	05100	RECOVERY ROOM	0	591	4,580	3,028	1,324	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,116	2,226	2,054	898	52.00
53.00	05300	ANESTHESIOLOGY	0	64	0	3,217	1,407	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,486	346	5,063	2,214	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	1,038	5,050	13	6	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	142	0	30	13	55.00
57.00	05700	CT SCAN	0	453	141	6,399	2,797	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	207	0	1,224	535	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	387	1,192	3,536	1,546	59.00
60.00	06000	LABORATORY	0	0	0	24,974	10,918	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	33	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,125	492	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,198	0	7,578	3,313	65.00
66.00	06600	PHYSICAL THERAPY	0	1,901	0	3,863	1,689	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	737	0	2,719	1,189	67.00
68.00	06800	SPEECH PATHOLOGY	0	209	0	371	162	68.00
69.00	06900	ELECTROCARDIOLOGY	0	706	656	6,366	2,783	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	184	218	65	28	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,415	4,116	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,939	3,033	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	28,158	12,310	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4	2	76.00
76.01	03950	IP RENAL DIALYSIS	0	376	0	2,842	1,243	76.01
76.97	07697	CARDIAC REHABILITATION	0	101	267	36	16	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	678	2,786	9	4	90.00
91.00	09100	EMERGENCY	0	4,742	36,633	13,997	6,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	331,832	56,008	257,791	245,784	107,542	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20	210	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	0	16	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01
194.02	07952	FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0180			Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description		DI ETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY		
		10.00	11.00	13.00	14.00	15.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	331,832	56,044	258,001	245,784	107,542		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0180

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

Worksheet B
Part II
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
				16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
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	161,944				16.00
17.00 01700	SOCIAL SERVICE	0	0			17.00
20.00 02000	NURSING SCHOOL	0	0	0		20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		10,882	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			37,164
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			22.00
23.00 02300	PARAMED ED PRGM-PHARMACY	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	124,927	0			30.00
31.00 03100	INTENSIVE CARE UNIT	7,223	0			31.00
40.00 04000	SUBPROVIDER - I PF	7,030	0			40.00
41.00 04100	SUBPROVIDER - I RF	6,635	0			41.00
43.00 04300	NURSERY	4,730	0			43.00
44.00 04400	SKILLED NURSING FACILITY	11,399	0			44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0			50.00
51.00 05100	RECOVERY ROOM	0	0			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00 05300	ANESTHESIOLOGY	0	0			53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0			54.00
54.01 03190	OUTPATIENT ONCOLOGY	0	0			54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0			55.00
57.00 05700	CT SCAN	0	0			57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0			58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0			59.00
60.00 06000	LABORATORY	0	0			60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0			62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00 06500	RESPIRATORY THERAPY	0	0			65.00
66.00 06600	PHYSICAL THERAPY	0	0			66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0			67.00
68.00 06800	SPEECH PATHOLOGY	0	0			68.00
69.00 06900	ELECTROCARDIOLOGY	0	0			69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00 07400	RENAL DIALYSIS	0	0			74.00
75.00 07500	ASC (NON-DISTINCT PART)	0	0			75.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0			76.00
76.01 03950	I P RENAL DIALYSIS	0	0			76.01
76.97 07697	CARDIAC REHABILITATION	0	0			76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0			76.98
76.99 07699	LI THOTRI PSY	0	0			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0			90.00
91.00 09100	EMERGENCY	0	0			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	161,944	0	0	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0			190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0			192.00
193.00 19300	NONPAID WORKERS	0	0			193.00
194.00 07950	CONVENT	0	0			194.00
194.01 07951	OUTPATIENT PHARMACY	0	0			194.01

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING SCHOOL	INTERNS & RESIDENTS		
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
194.02 07952 FUND DEVELOPMENT	16.00	17.00	20.00	21.00	22.00	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
200.00 Cross Foot Adjustments	0	0	0	10,882	37,164	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	161,944	0	0	10,882	37,164	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm
Cost Center Description	PARAMED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	23.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
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
20.00 02000	NURSING SCHOOL					20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00 02300	PARAMED PRGM-PHARMACY	3,026				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS		3,312,614	0	3,312,614	30.00
31.00 03100	INTENSIVE CARE UNIT		209,865	0	209,865	31.00
40.00 04000	SUBPROVIDER - I PF		104,361	0	104,361	40.00
41.00 04100	SUBPROVIDER - I RF		147,921	0	147,921	41.00
43.00 04300	NURSERY		42,216	0	42,216	43.00
44.00 04400	SKILLED NURSING FACILITY		180,150	0	180,150	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM		779,299	0	779,299	50.00
51.00 05100	RECOVERY ROOM		59,229	0	59,229	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM		330,208	0	330,208	52.00
53.00 05300	ANESTHESIOLOGY		12,153	0	12,153	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC		300,936	0	300,936	54.00
54.01 03190	OUTPATIENT ONCOLOGY		41,456	0	41,456	54.01
55.00 05500	RADIOLOGY-THERAPEUTIC		18,430	0	18,430	55.00
57.00 05700	CT SCAN		40,124	0	40,124	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)		14,092	0	14,092	58.00
59.00 05900	CARDIAC CATHETERIZATION		80,473	0	80,473	59.00
60.00 06000	LABORATORY		318,451	0	318,451	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS		217	0	217	62.30
63.00 06300	BLOOD STORING, PROCESSING & TRANS.		21,985	0	21,985	63.00
65.00 06500	RESPIRATORY THERAPY		33,394	0	33,394	65.00
66.00 06600	PHYSICAL THERAPY		134,978	0	134,978	66.00
67.00 06700	OCCUPATIONAL THERAPY		20,923	0	20,923	67.00
68.00 06800	SPEECH PATHOLOGY		1,812	0	1,812	68.00
69.00 06900	ELECTROCARDIOLOGY		118,022	0	118,022	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY		29,329	0	29,329	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT		49,990	0	49,990	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		35,334	0	35,334	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		70,509	0	70,509	73.00
74.00 07400	RENAL DIALYSIS		0	0	0	74.00
75.00 07500	ASC (NON-DISTINCT PART)		0	0	0	75.00
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		172,703	0	172,703	76.00
76.01 03950	IP RENAL DIALYSIS		15,212	0	15,212	76.01
76.97 07697	CARDIAC REHABILITATION		46,792	0	46,792	76.97
76.98 07698	HYPERBARIAC OXYGEN THERAPY		0	0	0	76.98
76.99 07699	LI THOTRI PSY		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC		349,283	0	349,283	90.00
91.00 09100	EMERGENCY		2,160,245	0	2,160,245	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)			0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	9,252,706	0	9,252,706	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		8,875	0	8,875	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES		1,543,979	0	1,543,979	192.00
193.00 19300	NONPAID WORKERS		0	0	0	193.00
194.00 07950	CONVENT		108,063	0	108,063	194.00
194.01 07951	OUTPATIENT PHARMACY		12,332	0	12,332	194.01

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description		PARAMED ED PRGM-PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		23.00	24.00	25.00	26.00		
194.02	07952 FUND DEVELOPMENT		3,561	0	3,561		194.02
194.03	07953 NURSING EDUC BLD UNUSED SPACE		0	0	0		194.03
200.00	Cross Foot Adjustments	3,026	51,072	0	51,072		200.00
201.00	Negative Cost Centers	0	76,424	0	76,424		201.00
202.00	TOTAL (sum lines 118 through 201)	3,026	11,057,012	0	11,057,012		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,005,668				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,005,668			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	6,951	6,951	48,838,900		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	59,768	59,768	4,943,354	-69,913,933	93,182,670
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	122,114	122,114	1,270,004	0	6,871,361
8.00 00800	LAUNDRY & LINEN SERVICE	4,201	4,201	56,686	0	482,478
9.00 00900	HOUSEKEEPING	12,636	12,636	933,550	0	1,684,100
10.00 01000	DIETARY	25,086	25,086	438,586	0	1,106,293
11.00 01100	CAFETERIA	3,752	3,752	552,458	0	1,074,826
13.00 01300	NURSING ADMINISTRATION	19,232	19,232	896,670	0	1,183,974
14.00 01400	CENTRAL SERVICES & SUPPLY	18,852	18,852	166,482	0	279,191
15.00 01500	PHARMACY	6,799	6,799	2,023,309	0	2,400,902
16.00 01600	MEDICAL RECORDS & LIBRARY	11,809	11,809	23,196	11	1,329,861
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,290,676	0	1,290,676
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,167	2,167	968,061	0	1,111,467
23.00 02300	PARAMED ED PRGM-PHARMACY	0	0	90,859	0	411,394
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	193,862	193,862	14,090,020	0	20,135,601
31.00 03100	INTENSIVE CARE UNIT	10,080	10,080	2,312,905	0	2,565,626
40.00 04000	SUBPROVIDER - I PF	4,857	4,857	731,168	4	790,617
41.00 04100	SUBPROVIDER - I RF	8,283	8,283	578,830	0	677,316
43.00 04300	NURSERY	1,851	1,851	341,520	0	378,977
44.00 04400	SKILLED NURSING FACILITY	9,294	9,294	1,271,439	0	1,468,838
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	53,314	53,314	3,253,486	0	4,324,823
51.00 05100	RECOVERY ROOM	3,494	3,494	428,899	0	473,713
52.00 05200	DELIVERY ROOM & LABOR ROOM	24,449	24,449	809,286	0	1,073,187
53.00 05300	ANESTHESIOLOGY	514	514	46,227	0	117,137
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,044	21,044	1,802,634	0	2,087,361
54.01 03190	OUTPATIENT ONCOLOGY	226	226	752,685	0	4,524,135
55.00 05500	RADIOLOGY-THERAPEUTIC	1,290	1,290	102,790	0	224,369
57.00 05700	CT SCAN	2,156	2,156	328,726	0	352,432
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	794	794	149,828	0	265,210
59.00 05900	CARDIAC CATHETERIZATION	5,491	5,491	280,421	0	367,538
60.00 06000	LABORATORY	18,850	18,850	0	0	5,541,551
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	23,695	0	26,090
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,565	1,565	0	0	21,729
65.00 06500	RESPIRATORY THERAPY	1,132	1,132	868,616	0	947,745
66.00 06600	PHYSICAL THERAPY	8,937	8,937	1,378,889	0	1,492,281
67.00 06700	OCCUPATIONAL THERAPY	962	962	534,650	0	546,257
68.00 06800	SPEECH PATHOLOGY	0	0	151,396	0	151,670
69.00 06900	ELECTROCARDIOLOGY	7,909	7,909	511,606	0	648,350
70.00 07000	ELECTROENCEPHALOGRAPHY	2,144	2,144	133,108	0	161,716
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,169,984
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,596,430
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,259,986
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	12,070	12,070	0	0	2,381,157
76.01 03950	I P RENAL DIALYSIS	607	607	272,389	0	375,384
76.97 07697	CARDIAC REHABILITATION	3,529	3,529	72,997	0	109,943
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LI THOTRI PSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	26,249	26,249	491,809	0	936,908
91.00 09100	EMERGENCY	158,692	158,692	3,438,665	0	5,677,971
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	877,012	877,012	48,812,575	-69,913,933	91,098,555
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	683	683	0	0	7,509
192.00 19200	PHYSICIANS' PRIVATE OFFICES	118,860	118,860	14,469	0	1,193,612
193.00 19300	NONPAID WORKERS	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
194.00 07950 CONVENT	8,292	8,292	11,856	0	133,423	194.00	
194.01 07951 OUTPATIENT PHARMACY	547	547	0	0	746,558	194.01	
194.02 07952 FUND DEVELOPMENT	274	274	0	0	3,013	194.02	
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03	
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)	4,036,568	7,020,444	-6,950,953		69,913,933	202.00	
203.00 Unit cost multiplier (Wkst. B, Part I)	4.013818	6.980876	0.000000		0.750289	203.00	
204.00 Cost to be allocated (per Wkst. B, Part II)			76,424		657,131	204.00	
205.00 Unit cost multiplier (Wkst. B, Part II)			0.001565		0.007052	205.00	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	816,835			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,201	687,679		8.00
9.00	00900	HOUSEKEEPING	0	12,636	35,493	799,998	9.00
10.00	01000	DIETARY	0	25,086	0	25,086	51,347
11.00	01100	CAFETERIA	0	3,752	0	3,752	0
13.00	01300	NURSING ADMINISTRATION	0	19,232	0	19,232	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,852	958	18,852	0
15.00	01500	PHARMACY	0	6,799	0	6,799	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,809	0	11,809	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,167	0	2,167	0
23.00	02300	PARAMED ED PRGM-PHARMACY	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	193,862	228,819	193,862	40,802
31.00	03100	INTENSIVE CARE UNIT	0	10,080	18,889	10,080	2,359
40.00	04000	SUBPROVIDER - I/P	0	4,857	30,807	4,857	2,296
41.00	04100	SUBPROVIDER - I/R	0	8,283	37,318	8,283	2,167
43.00	04300	NURSERY	0	1,851	0	1,851	0
44.00	04400	SKILLED NURSING FACILITY	0	9,294	22,738	9,294	3,723
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	53,314	86,904	53,314	0
51.00	05100	RECOVERY ROOM	0	3,494	14,970	3,494	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,449	6,606	24,449	0
53.00	05300	ANESTHESIOLOGY	0	514	0	514	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,044	51,935	21,044	0
54.01	03190	OUTPATIENT ONCOLOGY	0	226	6,357	226	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,290	0	1,290	0
57.00	05700	CT SCAN	0	2,156	0	2,156	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	794	0	794	0
59.00	05900	CARDIAC CATHETERIZATION	0	5,491	3,559	5,491	0
60.00	06000	LABORATORY	0	18,850	0	18,850	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,565	0	1,565	0
65.00	06500	RESPIRATORY THERAPY	0	1,132	0	1,132	0
66.00	06600	PHYSICAL THERAPY	0	8,937	18,957	8,937	0
67.00	06700	OCCUPATIONAL THERAPY	0	962	0	962	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	7,909	9,457	7,909	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,144	0	2,144	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	12,070	0	12,070	0
76.01	03950	I/P RENAL DIALYSIS	0	607	3,195	607	0
76.97	07697	CARDIAC REHABILITATION	0	3,529	163	3,529	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	26,249	1,781	26,249	0
91.00	09100	EMERGENCY	0	158,692	108,199	158,692	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	688,179	687,105	671,342	51,347
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	683	0	683	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	118,860	574	118,860	0
193.00	19300	NONPAID WORKERS	0	0	0	0	0
194.00	07950	CONVENT	0	8,292	0	8,292	0
194.01	07951	OUTPATIENT PHARMACY	0	547	0	547	0
194.02	07952	FUND DEVELOPMENT	0	274	0	274	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
194.03	07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
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)	0	12,026,868	906,330	3,180,489	2,405,424	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	14.723742	1.317955	3.975621	46.846437	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	1,391,063	56,745	175,253	331,832	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	1.702991	0.082517	0.219067	6.462539	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description			CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING HOURS)	CENTRAL SERVICES & SUPPLY (INPATIENT REVENUE)	PHARMACY (INPATIENT REVENUE)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	40,644,262					11.00
13.00	01300	NURSING ADMINISTRATION	896,670	538,506				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	166,482	0	423,051,229			14.00
15.00	01500	PHARMACY	2,023,309	0	0	423,051,229		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	23,196	0	0	0	52,892	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,290,676	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	968,061	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-PHARMACY	90,859	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,090,020	272,895	130,298,922	130,298,922	40,802	30.00
31.00	03100	INTENSIVE CARE UNIT	2,312,905	47,114	14,111,317	14,111,317	2,359	31.00
40.00	04000	SUBPROVIDER - I PF	731,168	13,141	5,192,470	5,192,470	2,296	40.00
41.00	04100	SUBPROVIDER - I RF	578,830	14,142	5,824,150	5,824,150	2,167	41.00
43.00	04300	NURSEY	341,520	8,108	7,841,239	7,841,239	1,545	43.00
44.00	04400	SKILLED NURSING FACILITY	1,271,439	15,109	4,092,349	4,092,349	3,723	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,253,486	54,645	26,727,798	26,727,798	0	50.00
51.00	05100	RECOVERY ROOM	428,899	9,559	5,211,378	5,211,378	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	809,286	4,646	3,534,911	3,534,911	0	52.00
53.00	05300	ANESTHESIOLOGY	46,227	0	5,537,738	5,537,738	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,802,634	723	8,714,894	8,714,894	0	54.00
54.01	03190	OUTPATIENT ONCOLOGY	752,685	10,540	22,934	22,934	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	102,790	0	51,774	51,774	0	55.00
57.00	05700	CT SCAN	328,726	295	11,013,302	11,013,302	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	149,828	0	2,105,875	2,105,875	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	280,421	2,488	6,086,233	6,086,233	0	59.00
60.00	06000	LABORATORY	0	0	42,984,668	42,984,668	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	23,695	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	1,937,157	1,937,157	0	63.00
65.00	06500	RESPIRATORY THERAPY	868,616	0	13,042,836	13,042,836	0	65.00
66.00	06600	PHYSICAL THERAPY	1,378,889	0	6,649,113	6,649,113	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	534,650	0	4,680,510	4,680,510	0	67.00
68.00	06800	SPEECH PATHOLOGY	151,396	0	639,223	639,223	0	68.00
69.00	06900	ELECTROCARDIOLOGY	511,606	1,370	10,956,827	10,956,827	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	133,108	456	111,725	111,725	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	16,205,608	16,205,608	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	11,942,873	11,942,873	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	48,465,053	48,465,053	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	6,287	6,287	0	76.00
76.01	03950	I/P RENAL DIALYSIS	272,389	0	4,892,011	4,892,011	0	76.01
76.97	07697	CARDIAC REHABILITATION	72,997	558	62,699	62,699	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	491,809	5,816	15,629	15,629	0	90.00
91.00	09100	EMERGENCY	3,438,665	76,462	24,091,726	24,091,726	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILITY ZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	40,617,937	538,067	423,051,229	423,051,229	52,892	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,469	439	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	CONVENT	11,856	0	0	0	0	194.00
194.01	07951	OUTPATIENT PHARMACY	0	0	0	0	0	194.01

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description		CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING HO URS)	CENTRAL SERVICES & SUPPLY (INPATIENT REVENUE)	PHARMACY (INPATIENT REVENUE)	MEDICAL RECORDS & LIBRARY (PATIENT DA YS)	
		11.00	13.00	14.00	15.00	16.00	
194.02	07952	FUND DEVELOPMENT	0	0	0	0	194.02
194.03	07953	NURSING EDUC BLD UNUSED SPACE	0	0	0	0	194.03
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)	1,951,416	2,474,974	850,441	4,426,552	2,549,576
203.00		Unit cost multiplier (Wkst. B, Part I)	0.048012	4.596001	0.002010	0.010463	48.203433
204.00		Cost to be allocated (per Wkst. B, Part II)	56,044	258,001	245,784	107,542	161,944
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001379	0.479105	0.000581	0.000254	3.061786
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	SOCIAL SERVICE (DAYS)	NURSING SCHOOL (PATIENT DAYS)	INTERNS & RESIDENTS		PARAMED PRGM-PHARMACY (ASSIGNED TIME)	
			SERVICES-SALARY & FRINGES APPRV (PATIENT DAYS)	SERVICES-OTHER PRGM COSTS APPRV (PATIENT DAYS)		
			17.00	20.00		
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
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	0					17.00
20.00 02000 NURSING SCHOOL	0	0				20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0		44,706			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0			44,706		22.00
23.00 02300 PARAMED PRGM-PHARMACY	0				100	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	0	0	40,802	40,802	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	2,359	2,359	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00 04300 NURSERY	0	0	1,545	1,545	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	44,706	44,706	100	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0180

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description	SOCIAL SERVICE (DAYS)	NURSING SCHOOL (PATIENT DAYS)	INTERNS & RESIDENTS		PARAMED PRGM-PHARMACY (ASSIGNED TIME)	
			SERVICES-SALAR Y & FRINGES APPRV (PATIENT DA YS)	SERVICES-OTHER PRGM COSTS APPRV (PATIENT DA YS)		
			17.00	20.00		
194.00 07950 CONVENT	0	0	0	0	0	194.00
194.01 07951 OUTPATIENT PHARMACY	0	0	0	0	0	194.01
194.02 07952 FUND DEVELOPMENT	0	0	0	0	0	194.02
194.03 07953 NURSING EDUC BLD UNUSED SPACE	0	0	0	0	0	194.03
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)	0	0	2,321,024	2,032,388	724,420	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	51.917505	45.461191	7,244.200000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0	10,882	37,164	3,026	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.243413	0.831298	30.260000	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)			0			206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000			0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 3:54 pm	
			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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	46,604,227	46,604,227	0	46,604,227	30.00
31.00	03100 INTENSIVE CARE UNIT	5,431,788	5,431,788	0	5,431,788	31.00
40.00	04000 SUBPROVIDER - IPF	1,893,734	1,893,734	0	1,893,734	40.00
41.00	04100 SUBPROVIDER - IRF	1,760,975	1,760,975	0	1,760,975	41.00
43.00	04300 NURSERY	923,871	923,871	0	923,871	43.00
44.00	04400 SKILLED NURSING FACILITY	3,310,049	3,310,049	0	3,310,049	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9,421,894	9,421,894	0	9,421,894	50.00
51.00	05100 RECOVERY ROOM	1,043,728	1,043,728	0	1,043,728	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,448,573	2,448,573	0	2,448,573	52.00
53.00	05300 ANESTHESIOLOGY	285,926	285,926	0	285,926	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,314,014	4,314,014	0	4,314,014	54.00
54.01	03190 OUTPATIENT ONCOLOGY	8,016,014	8,016,014	0	8,016,014	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	422,415	422,415	0	422,415	55.00
57.00	05700 CT SCAN	811,681	811,681	0	811,681	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	512,503	512,503	0	512,503	58.00
59.00	05900 CARDIAC CATHETERIZATION	851,479	851,479	0	851,479	59.00
60.00	06000 LABORATORY	10,587,947	10,587,947	0	10,587,947	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	46,803	46,803	0	46,803	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	91,459	91,459	0	91,459	63.00
65.00	06500 RESPIRATORY THERAPY	1,884,382	1,884,382	0	1,884,382	65.00
66.00	06600 PHYSICAL THERAPY	2,953,161	2,953,161	0	2,953,161	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,058,147	1,058,147	0	1,058,147	67.00
68.00	06800 SPEECH PATHOLOGY	280,708	280,708	0	280,708	68.00
69.00	06900 ELECTROCARDIOLOGY	1,462,681	1,462,681	0	1,462,681	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	333,023	333,023	0	333,023	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,251,098	9,251,098	0	9,251,098	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,443,755	6,443,755	0	6,443,755	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,785,132	8,785,132	0	8,785,132	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,393,494	4,393,494	0	4,393,494	76.00
76.01	03950 IP RENAL DIALYSIS	746,687	746,687	0	746,687	76.01
76.97	07697 CARDIAC REHABILITATION	265,489	265,489	0	265,489	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	2,183,585	2,183,585	0	2,183,585	90.00
91.00	09100 EMERGENCY	13,865,142	13,865,142	0	13,865,142	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,467,420	2,467,420	0	2,467,420	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)	155,152,984	155,152,984	0	155,152,984	200.00
201.00	Less Observation Beds	2,467,420	2,467,420	0	2,467,420	201.00
202.00	Total (see instructions)	152,685,564	152,685,564	0	152,685,564	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet C Part I Date/Time Prepared: 11/28/2018 3:54 pm		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	128,957,365		128,957,365				30.00
31.00	03100	INTENSIVE CARE UNIT	14,111,317		14,111,317				31.00
40.00	04000	SUBPROVIDER - IPF	5,192,470		5,192,470				40.00
41.00	04100	SUBPROVIDER - IRF	5,824,150		5,824,150				41.00
43.00	04300	NURSERY	7,841,239		7,841,239				43.00
44.00	04400	SKILLED NURSING FACILITY	4,092,349		4,092,349				44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	26,727,798	45,620,760	72,348,558	0.130229	0.000000		50.00
51.00	05100	RECOVERY ROOM	5,211,378	6,070,685	11,282,063	0.092512	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,534,911	362,272	3,897,183	0.628293	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	5,537,738	8,424,110	13,961,848	0.020479	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,714,894	33,488,721	42,203,615	0.102219	0.000000		54.00
54.01	03190	OUTPATIENT ONCOLOGY	22,934	42,960,371	42,983,305	0.186491	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	51,774	5,746,513	5,798,287	0.072852	0.000000		55.00
57.00	05700	CT SCAN	11,013,302	17,868,482	28,881,784	0.028104	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,105,875	5,787,562	7,893,437	0.064928	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	6,086,233	2,750,726	8,836,959	0.096354	0.000000		59.00
60.00	06000	LABORATORY	42,984,668	30,439,416	73,424,084	0.144203	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	53,911	53,911	0.868153	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,937,157	313,940	2,251,097	0.040629	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	13,042,836	1,684,391	14,727,227	0.127952	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	6,649,113	8,643,071	15,292,184	0.193116	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,680,510	1,988,615	6,669,125	0.158664	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	639,223	43,362	682,585	0.411243	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	10,956,827	13,542,381	24,499,208	0.059703	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,725	541,039	652,764	0.510174	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,205,608	8,988,723	25,194,331	0.367190	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,942,873	7,631,513	19,574,386	0.329193	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,465,053	20,961,801	69,426,854	0.126538	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,287	6,269,161	6,275,448	0.700108	0.000000		76.00
76.01	03950	IP RENAL DIALYSIS	4,892,011	335,343	5,227,354	0.142842	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	62,699	264,894	327,593	0.810423	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	15,629	3,221,737	3,237,366	0.674494	0.000000		90.00
91.00	09100	EMERGENCY	24,091,726	58,413,017	82,504,743	0.168053	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,557	13,768,150	15,109,707	0.163300	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
114.00	11400	UTILIZATION REVIEW-SNF							114.00
200.00		Subtotal (see instructions)	423,051,229	346,184,667	769,235,896				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	423,051,229	346,184,667	769,235,896				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 3:54 pm
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.130229		50.00
51.00	05100	RECOVERY ROOM	0.092512		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.628293		52.00
53.00	05300	ANESTHESIOLOGY	0.020479		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102219		54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.186491		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072852		55.00
57.00	05700	CT SCAN	0.028104		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.064928		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.096354		59.00
60.00	06000	LABORATORY	0.144203		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.868153		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.040629		63.00
65.00	06500	RESPIRATORY THERAPY	0.127952		65.00
66.00	06600	PHYSICAL THERAPY	0.193116		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158664		67.00
68.00	06800	SPEECH PATHOLOGY	0.411243		68.00
69.00	06900	ELECTROCARDIOLOGY	0.059703		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.510174		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.329193		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126538		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108		76.00
76.01	03950	I P RENAL DIALYSIS	0.142842		76.01
76.97	07697	CARDIAC REHABILITATION	0.810423		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.674494		90.00
91.00	09100	EMERGENCY	0.168053		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.163300		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 14-0180

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

Worksheet C
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Dissallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	46,604,227		46,604,227	0	46,604,227	30.00
31.00	03100 INTENSIVE CARE UNIT	5,431,788		5,431,788	0	5,431,788	31.00
40.00	04000 SUBPROVIDER - IPF	1,893,734		1,893,734	0	1,893,734	40.00
41.00	04100 SUBPROVIDER - IRF	1,760,975		1,760,975	0	1,760,975	41.00
43.00	04300 NURSERY	923,871		923,871	0	923,871	43.00
44.00	04400 SKILLED NURSING FACILITY	3,310,049		3,310,049	0	3,310,049	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	9,421,894		9,421,894	0	9,421,894	50.00
51.00	05100 RECOVERY ROOM	1,043,728		1,043,728	0	1,043,728	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2,448,573		2,448,573	0	2,448,573	52.00
53.00	05300 ANESTHESIOLOGY	285,926		285,926	0	285,926	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,314,014		4,314,014	0	4,314,014	54.00
54.01	03190 OUTPATIENT ONCOLOGY	8,016,014		8,016,014	0	8,016,014	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	422,415		422,415	0	422,415	55.00
57.00	05700 CT SCAN	811,681		811,681	0	811,681	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	512,503		512,503	0	512,503	58.00
59.00	05900 CARDIAC CATHETERIZATION	851,479		851,479	0	851,479	59.00
60.00	06000 LABORATORY	10,587,947		10,587,947	0	10,587,947	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	46,803		46,803	0	46,803	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	91,459		91,459	0	91,459	63.00
65.00	06500 RESPIRATORY THERAPY	1,884,382	0	1,884,382	0	1,884,382	65.00
66.00	06600 PHYSICAL THERAPY	2,953,161	0	2,953,161	0	2,953,161	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,058,147	0	1,058,147	0	1,058,147	67.00
68.00	06800 SPEECH PATHOLOGY	280,708	0	280,708	0	280,708	68.00
69.00	06900 ELECTROCARDIOLOGY	1,462,681		1,462,681	0	1,462,681	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	333,023		333,023	0	333,023	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,251,098		9,251,098	0	9,251,098	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,443,755		6,443,755	0	6,443,755	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,785,132		8,785,132	0	8,785,132	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,393,494		4,393,494	0	4,393,494	76.00
76.01	03950 IP RENAL DIALYSIS	746,687		746,687	0	746,687	76.01
76.97	07697 CARDIAC REHABILITATION	265,489		265,489	0	265,489	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	2,183,585		2,183,585	0	2,183,585	90.00
91.00	09100 EMERGENCY	13,865,142		13,865,142	0	13,865,142	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,467,420		2,467,420	0	2,467,420	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
200.00	Subtotal (see instructions)	155,152,984	0	155,152,984	0	155,152,984	200.00
201.00	Less Observation Beds	2,467,420		2,467,420		2,467,420	201.00
202.00	Total (see instructions)	152,685,564	0	152,685,564	0	152,685,564	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet C Part I Date/Time Prepared: 11/28/2018 3:54 pm	
			Title XIX			Hospital		Cost
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	128,957,365		128,957,365			30.00
31.00	03100	INTENSIVE CARE UNIT	14,111,317		14,111,317			31.00
40.00	04000	SUBPROVIDER - IPF	5,192,470		5,192,470			40.00
41.00	04100	SUBPROVIDER - IRF	5,824,150		5,824,150			41.00
43.00	04300	NURSERY	7,841,239		7,841,239			43.00
44.00	04400	SKILLED NURSING FACILITY	4,092,349		4,092,349			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,727,798	45,620,760	72,348,558	0.130229	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,211,378	6,070,685	11,282,063	0.092512	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,534,911	362,272	3,897,183	0.628293	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	5,537,738	8,424,110	13,961,848	0.020479	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,714,894	33,488,721	42,203,615	0.102219	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	22,934	42,960,371	42,983,305	0.186491	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	51,774	5,746,513	5,798,287	0.072852	0.000000	55.00
57.00	05700	CT SCAN	11,013,302	17,868,482	28,881,784	0.028104	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,105,875	5,787,562	7,893,437	0.064928	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	6,086,233	2,750,726	8,836,959	0.096354	0.000000	59.00
60.00	06000	LABORATORY	42,984,668	30,439,416	73,424,084	0.144203	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	53,911	53,911	0.868153	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,937,157	313,940	2,251,097	0.040629	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	13,042,836	1,684,391	14,727,227	0.127952	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	6,649,113	8,643,071	15,292,184	0.193116	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,680,510	1,988,615	6,669,125	0.158664	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	639,223	43,362	682,585	0.411243	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,956,827	13,542,381	24,499,208	0.059703	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,725	541,039	652,764	0.510174	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16,205,608	8,988,723	25,194,331	0.367190	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,942,873	7,631,513	19,574,386	0.329193	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,465,053	20,961,801	69,426,854	0.126538	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	6,287	6,269,161	6,275,448	0.700108	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	4,892,011	335,343	5,227,354	0.142842	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	62,699	264,894	327,593	0.810423	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	15,629	3,221,737	3,237,366	0.674494	0.000000	90.00
91.00	09100	EMERGENCY	24,091,726	58,413,017	82,504,743	0.168053	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,341,557	13,768,150	15,109,707	0.163300	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	423,051,229	346,184,667	769,235,896			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	423,051,229	346,184,667	769,235,896			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 3:54 pm
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - IPF			40.00
41.00	04100 SUBPROVIDER - IRF			41.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000		76.00
76.01	03950 IP RENAL DIALYSIS	0.000000		76.01
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		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
114.00	11400 UTILIZATION REVIEW-SNF			114.00
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: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part I Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,312,614	0	3,312,614	42,762	77.47	30.00
31.00	INTENSIVE CARE UNIT	209,865	0	209,865	2,359	88.96	31.00
40.00	SUBPROVIDER - IPF	104,361	0	104,361	2,296	45.45	40.00
41.00	SUBPROVIDER - IRF	147,921	0	147,921	2,167	68.26	41.00
43.00	NURSERY	42,216		42,216	1,545	27.32	43.00
44.00	SKILLED NURSING FACILITY	180,150		180,150	3,723	48.39	44.00
200.00	Total (lines 30 through 199)	3,997,127		3,997,127	54,852		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,914	768,038				30.00
31.00	INTENSIVE CARE UNIT	746	66,364				31.00
40.00	SUBPROVIDER - IPF	846	38,451				40.00
41.00	SUBPROVIDER - IRF	888	60,615				41.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	2,681	129,734				44.00
200.00	Total (lines 30 through 199)	15,075	1,063,202				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	779,299	72,348,558	0.010771	8,579,110	92,406	50.00
51.00	05100	RECOVERY ROOM	59,229	11,282,063	0.005250	1,456,743	7,648	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	330,208	3,897,183	0.084730	0	0	52.00
53.00	05300	ANESTHESIOLOGY	12,153	13,961,848	0.000870	1,693,664	1,473	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,936	42,203,615	0.007131	2,804,191	19,997	54.00
54.01	03190	OUTPATIENT ONCOLOGY	41,456	42,983,305	0.000964	6,952	7	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	18,430	5,798,287	0.003179	51,774	165	55.00
57.00	05700	CT SCAN	40,124	28,881,784	0.001389	3,247,381	4,511	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,092	7,893,437	0.001785	590,462	1,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	80,473	8,836,959	0.009106	1,955,190	17,804	59.00
60.00	06000	LABORATORY	318,451	73,424,084	0.004337	12,215,919	52,980	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	217	53,911	0.004025	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,985	2,251,097	0.009766	699,176	6,828	63.00
65.00	06500	RESPIRATORY THERAPY	33,394	14,727,227	0.002268	4,411,315	10,005	65.00
66.00	06600	PHYSICAL THERAPY	134,978	15,292,184	0.008827	822,705	7,262	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,923	6,669,125	0.003137	493,017	1,547	67.00
68.00	06800	SPEECH PATHOLOGY	1,812	682,585	0.002655	161,143	428	68.00
69.00	06900	ELECTROCARDIOLOGY	118,022	24,499,208	0.004817	3,749,703	18,062	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,329	652,764	0.044930	30,208	1,357	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	49,990	25,194,331	0.001984	5,201,734	10,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,334	19,574,386	0.001805	4,022,072	7,260	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,509	69,426,854	0.001016	14,282,224	14,511	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	172,703	6,275,448	0.027520	4,162	115	76.00
76.01	03950	IP RENAL DIALYSIS	15,212	5,227,354	0.002910	2,090,531	6,083	76.01
76.97	07697	CARDIAC REHABILITATION	46,792	327,593	0.142836	27,083	3,868	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	349,283	3,237,366	0.107891	13,018	1,405	90.00
91.00	09100	EMERGENCY	2,160,245	82,504,743	0.026183	6,443,784	168,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	175,384	15,109,707	0.011607	510,962	5,931	92.00
200.00		Total (lines 50 through 199)	5,430,963	603,217,006		75,564,223	461,745	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of 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	42,762	0.00	9,914	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	2,359	0.00	746	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	2,296	0.00	846	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	2,167	0.00	888	41.00	
43.00	04300	NURSERY	0	0	1,545	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	3,723	0.00	2,681	44.00	
200.00		Total (lines 30 through 199)	0	0	54,852	0.00	15,075	200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
			9.00						
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
40.00	04000	SUBPROVIDER - IPF	0						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description	Title XVIII				Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	724,420	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	0	76.00
76.01 03950 I/P RENAL DIALYSIS	0	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	724,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	72,348,558	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,282,063	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,897,183	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,961,848	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,203,615	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	42,983,305	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,798,287	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,881,784	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	7,893,437	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,836,959	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,424,084	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	53,911	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,251,097	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,727,227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,292,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,669,125	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	682,585	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,499,208	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	652,764	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,194,331	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,574,386	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	724,420	724,420	69,426,854	0.010434	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	6,275,448	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	5,227,354	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	327,593	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,237,366	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	82,504,743	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	15,109,707	0.000000	92.00
200.00		Total (lines 50 through 199)	0	724,420	724,420	603,217,006		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description		Title XVIII					Hospital	
		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)	PPS	
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0.000000	8,579,110	0	8,894,222	0	50.00	
51.00	05100 RECOVERY ROOM	0.000000	1,456,743	0	1,040,190	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.000000	1,693,664	0	1,549,876	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	2,804,191	0	4,892,534	0	54.00	
54.01	03190 OUTPATIENT ONCOLOGY	0.000000	6,952	0	12,176,188	0	54.01	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	51,774	0	1,683,971	0	55.00	
57.00	05700 CT SCAN	0.000000	3,247,381	0	3,671,828	0	57.00	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	590,462	0	1,055,252	0	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0.000000	1,955,190	0	850,217	0	59.00	
60.00	06000 LABORATORY	0.000000	12,215,919	0	4,818,710	0	60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	22,300	0	62.30	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	699,176	0	38,100	0	63.00	
65.00	06500 RESPIRATORY THERAPY	0.000000	4,411,315	0	241,161	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	822,705	0	49,353	0	66.00	
67.00	06700 OCCUPATIONAL THERAPY	0.000000	493,017	0	39,179	0	67.00	
68.00	06800 SPEECH PATHOLOGY	0.000000	161,143	0	4,779	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	0.000000	3,749,703	0	3,208,642	0	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	30,208	0	76,417	0	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	5,201,734	0	1,600,188	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,022,072	0	2,209,271	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.010434	14,282,224	149,021	4,388,424	45,789	73.00	
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	4,162	0	1,190,181	0	76.00	
76.01	03950 IP RENAL DIALYSIS	0.000000	2,090,531	0	136,692	0	76.01	
76.97	07697 CARDIAC REHABILITATION	0.000000	27,083	0	34,503	0	76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0.000000	13,018	0	626,976	0	90.00	
91.00	09100 EMERGENCY	0.000000	6,443,784	0	6,129,066	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	510,962	0	3,015,081	0	92.00	
200.00	Total (lines 50 through 199)		75,564,223	149,021	63,643,301	45,789	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
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		Title XVIII		Hospital		PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.130229	8,894,222	0	3,211	1,158,286	50.00
51.00	05100	RECOVERY ROOM	0.092512	1,040,190	0	0	96,230	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.628293	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020479	1,549,876	0	0	31,740	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102219	4,892,534	0	166	500,110	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.186491	12,176,188	0	15,042	2,270,749	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072852	1,683,971	0	0	122,681	55.00
57.00	05700	CT SCAN	0.028104	3,671,828	0	2,773	103,193	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.064928	1,055,252	0	501	68,515	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.096354	850,217	0	683	81,922	59.00
60.00	06000	LABORATORY	0.144203	4,818,710	0	0	694,872	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	22,300	0	0	19,360	62.30
63.00	06300	BLOOD STORAGE, PROCESSING & TRANS.	0.040629	38,100	0	0	1,548	63.00
65.00	06500	RESPIRATORY THERAPY	0.127952	241,161	0	0	30,857	65.00
66.00	06600	PHYSICAL THERAPY	0.193116	49,353	0	0	9,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158664	39,179	0	0	6,216	67.00
68.00	06800	SPEECH PATHOLOGY	0.411243	4,779	0	0	1,965	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059703	3,208,642	0	366	191,566	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.510174	76,417	0	0	38,986	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	1,600,188	0	0	587,573	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.329193	2,209,271	0	0	727,277	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126538	4,388,424	0	79,213	555,302	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	1,190,181	0	0	833,255	76.00
76.01	03950	IP RENAL DIALYSIS	0.142842	136,692	0	2	19,525	76.01
76.97	07697	CARDIAC REHABILITATION	0.810423	34,503	0	0	27,962	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.674494	626,976	0	0	422,892	90.00
91.00	09100	EMERGENCY	0.168053	6,129,066	0	0	1,030,008	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.163300	3,015,081	0	0	492,363	92.00
200.00		Subtotal (see instructions)		63,643,301	0	101,957	10,124,484	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		63,643,301	0	101,957	10,124,484	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	418		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	17		54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	2,805		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	78		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	33		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	66		59.00
60.00 06000 LABORATORY	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	22		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10,023		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
76.01 03950 IP RENAL DIALYSIS	0	0		76.01
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS				
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00	Subtotal (see instructions)	0	13,462	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	0	13,462	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part II Date/Time Prepared: 11/28/2018 3:54 pm	
Title XVIII				Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	779,299	72,348,558	0.010771	7,402	80	50.00
51.00	05100 RECOVERY ROOM	59,229	11,282,063	0.005250	290	2	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	330,208	3,897,183	0.084730	0	0	52.00
53.00	05300 ANESTHESIOLOGY	12,153	13,961,848	0.000870	1,112	1	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	300,936	42,203,615	0.007131	20,425	146	54.00
54.01	03190 OUTPATIENT ONCOLOGY	41,456	42,983,305	0.000964	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	18,430	5,798,287	0.003179	0	0	55.00
57.00	05700 CT SCAN	40,124	28,881,784	0.001389	41,388	57	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	14,092	7,893,437	0.001785	3,289	6	58.00
59.00	05900 CARDIAC CATHETERIZATION	80,473	8,836,959	0.009106	0	0	59.00
60.00	06000 LABORATORY	318,451	73,424,084	0.004337	262,805	1,140	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	217	53,911	0.004025	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	21,985	2,251,097	0.009766	46	0	63.00
65.00	06500 RESPIRATORY THERAPY	33,394	14,727,227	0.002268	44,657	101	65.00
66.00	06600 PHYSICAL THERAPY	134,978	15,292,184	0.008827	7,658	68	66.00
67.00	06700 OCCUPATIONAL THERAPY	20,923	6,669,125	0.003137	2,862	9	67.00
68.00	06800 SPEECH PATHOLOGY	1,812	682,585	0.002655	1,605	4	68.00
69.00	06900 ELECTROCARDIOLOGY	118,022	24,499,208	0.004817	52,860	255	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	29,329	652,764	0.044930	1,028	46	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	49,990	25,194,331	0.001984	23,585	47	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	35,334	19,574,386	0.001805	1,847	3	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	70,509	69,426,854	0.001016	474,279	482	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	172,703	6,275,448	0.027520	0	0	76.00
76.01	03950 IP RENAL DIALYSIS	15,212	5,227,354	0.002910	18,540	54	76.01
76.97	07697 CARDIAC REHABILITATION	46,792	327,593	0.142836	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	349,283	3,237,366	0.107891	0	0	90.00
91.00	09100 EMERGENCY	2,160,245	82,504,743	0.026183	246,864	6,464	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	15,109,707	0.000000	9,024	0	92.00
200.00	Total (lines 50 through 199)	5,255,579	603,217,006		1,221,566	8,965	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	724,420	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	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
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	724,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	72,348,558	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,282,063	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,897,183	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,961,848	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,203,615	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	42,983,305	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,798,287	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,881,784	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	7,893,437	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,836,959	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,424,084	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	53,911	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,251,097	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,727,227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,292,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,669,125	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	682,585	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,499,208	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	652,764	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,194,331	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,574,386	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	724,420	724,420	69,426,854	0.010434	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	6,275,448	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	5,227,354	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	327,593	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,237,366	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	82,504,743	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,109,707	0.000000	92.00
200.00		Total (lines 50 through 199)	0	724,420	724,420	603,217,006		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	7,402	0	865	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	290	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,112	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	20,425	0	2,414	0 54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.000000	0	0	23,051	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
57.00	05700	CT SCAN	0.000000	41,388	0	6,709	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3,289	0	76	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	36	0 59.00
60.00	06000	LABORATORY	0.000000	262,805	0	1,047	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	46	0	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	44,657	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,658	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,862	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,605	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	52,860	0	9,334	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	1,028	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	23,585	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	1,847	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.010434	474,279	4,949	9,267	97 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0 76.00
76.01	03950	IP RENAL DIALYSIS	0.000000	18,540	0	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LI THOTRI PSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	1	0 90.00
91.00	09100	EMERGENCY	0.000000	246,864	0	38	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	9,024	0	0	0 92.00
200.00		Total (lines 50 through 199)		1,221,566	4,949	52,838	97 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	Costs (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.130229	865	0	0	113	50.00
51.00 05100 RECOVERY ROOM	0.092512	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.628293	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.020479	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.102219	2,414	0	0	247	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0.186491	23,051	0	0	4,299	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.072852	0	0	0	0	55.00
57.00 05700 CT SCAN	0.028104	6,709	0	0	189	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.064928	76	0	0	5	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.096354	36	0	0	3	59.00
60.00 06000 LABORATORY	0.144203	1,047	0	0	151	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.040629	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.127952	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.193116	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.158664	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.411243	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.059703	9,334	0	0	557	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.510174	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.329193	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.126538	9,267	0	0	1,173	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	0	0	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0.142842	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0.810423	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.674494	1	0	0	1	90.00
91.00 09100 EMERGENCY	0.168053	38	0	0	6	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.163300	0	0	0	0	92.00
200.00	Subtotal (see instructions)		52,838	0	6,744	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		52,838	0	6,744	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	201.00
202.00	Net Charges (line 200 - line 201)	0	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part II Date/Time Prepared: 11/28/2018 3:54 pm	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	779,299	72,348,558	0.010771	162	2 50.00
51.00	05100	RECOVERY ROOM	59,229	11,282,063	0.005250	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	330,208	3,897,183	0.084730	0	0 52.00
53.00	05300	ANESTHESIOLOGY	12,153	13,961,848	0.000870	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,936	42,203,615	0.007131	36,695	262 54.00
54.01	03190	OUTPATIENT ONCOLOGY	41,456	42,983,305	0.000964	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	18,430	5,798,287	0.003179	0	0 55.00
57.00	05700	CT SCAN	40,124	28,881,784	0.001389	35,668	50 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	14,092	7,893,437	0.001785	9,505	17 58.00
59.00	05900	CARDIAC CATHETERIZATION	80,473	8,836,959	0.009106	0	0 59.00
60.00	06000	LABORATORY	318,451	73,424,084	0.004337	408,999	1,774 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	217	53,911	0.004025	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	21,985	2,251,097	0.009766	1,896	19 63.00
65.00	06500	RESPIRATORY THERAPY	33,394	14,727,227	0.002268	61,037	138 65.00
66.00	06600	PHYSICAL THERAPY	134,978	15,292,184	0.008827	999,327	8,821 66.00
67.00	06700	OCCUPATIONAL THERAPY	20,923	6,669,125	0.003137	616,295	1,933 67.00
68.00	06800	SPEECH PATHOLOGY	1,812	682,585	0.002655	95,772	254 68.00
69.00	06900	ELECTROCARDIOLOGY	118,022	24,499,208	0.004817	32,372	156 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	29,329	652,764	0.044930	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	49,990	25,194,331	0.001984	89,008	177 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	35,334	19,574,386	0.001805	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,509	69,426,854	0.001016	599,955	610 73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0 75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	172,703	6,275,448	0.027520	0	0 76.00
76.01	03950	IP RENAL DIALYSIS	15,212	5,227,354	0.002910	212,416	618 76.01
76.97	07697	CARDIAC REHABILITATION	46,792	327,593	0.142836	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	349,283	3,237,366	0.107891	0	0 90.00
91.00	09100	EMERGENCY	2,160,245	82,504,743	0.026183	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	15,109,707	0.000000	0	0 92.00
200.00		Total (lines 50 through 199)	5,255,579	603,217,006		3,199,107	14,831 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	724,420	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	724,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	72,348,558	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,282,063	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,897,183	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,961,848	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,203,615	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	42,983,305	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,798,287	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,881,784	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	7,893,437	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,836,959	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,424,084	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	53,911	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,251,097	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,727,227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,292,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,669,125	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	682,585	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,499,208	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	652,764	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,194,331	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,574,386	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	724,420	724,420	69,426,854	0.010434	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	6,275,448	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	5,227,354	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	327,593	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,237,366	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	82,504,743	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,109,707	0.000000	92.00
200.00		Total (lines 50 through 199)	0	724,420	724,420	603,217,006		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm	
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	162	0	247	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	36,695	0	6,381	0 54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.000000	0	0	6,588	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0 55.00
57.00	05700	CT SCAN	0.000000	35,668	0	5,164	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	9,505	0	22	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	23	0 59.00
60.00	06000	LABORATORY	0.000000	408,999	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	1,896	0	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	61,037	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	999,327	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	616,295	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	95,772	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	32,372	0	1,721	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	89,008	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.010434	599,955	6,260	2,646	28 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0 75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0 76.00
76.01	03950	IP RENAL DIALYSIS	0.000000	212,416	0	0	0 76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99	07699	LI THOTRI PSY	0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	12	0 90.00
91.00	09100	EMERGENCY	0.000000	0	0	76	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0 92.00
200.00		Total (lines 50 through 199)		3,199,107	6,260	22,880	28 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0.130229	247	0	267	32	50.00	
51.00 05100 RECOVERY ROOM	0.092512	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.628293	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0.020479	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.102219	6,381	0	15	652	54.00	
54.01 03190 OUTPATIENT ONCOLOGY	0.186491	6,588	0	0	1,229	54.01	
55.00 05500 RADIOLOGY-THERAPEUTIC	0.072852	0	0	0	0	55.00	
57.00 05700 CT SCAN	0.028104	5,164	0	253	145	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.064928	22	0	45	1	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0.096354	23	0	67	2	59.00	
60.00 06000 LABORATORY	0.144203	0	0	0	0	60.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	0	0	0	0	62.30	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.040629	0	0	0	0	63.00	
65.00 06500 RESPIRATORY THERAPY	0.127952	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0.193116	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0.158664	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0.411243	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0.059703	1,721	0	31	103	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0.510174	0	0	0	0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.329193	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.126538	2,646	0	7,376	335	73.00	
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00	
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	0	0	0	0	76.00	
76.01 03950 IP RENAL DIALYSIS	0.142842	0	0	0	0	76.01	
76.97 07697 CARDIAC REHABILITATION	0.810423	0	0	0	0	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0.674494	12	0	0	8	90.00	
91.00 09100 EMERGENCY	0.168053	76	0	0	13	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.163300	0	0	0	0	92.00	
200.00	Subtotal (see instructions)		22,880	0	8,054	2,520	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		22,880	0	8,054	2,520	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	35	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	2	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	7	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	6	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	2	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	933	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00	Subtotal (see instructions)	988	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	201.00
202.00	Net Charges (line 200 - line 201)	988	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	724,420	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	724,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	72,348,558	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,282,063	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,897,183	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,961,848	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,203,615	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	42,983,305	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,798,287	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,881,784	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	7,893,437	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,836,959	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,424,084	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	53,911	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,251,097	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,727,227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,292,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,669,125	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	682,585	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,499,208	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	652,764	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,194,331	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,574,386	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	724,420	724,420	69,426,854	0.010434	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	6,275,448	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	5,227,354	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	327,593	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,237,366	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	82,504,743	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	15,109,707	0.000000	92.00
200.00		Total (lines 50 through 199)	0	724,420	724,420	603,217,006		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	82,512	0	0	0	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	15,415	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	1,234,572	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	4,339	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	1,073,991	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	1,608,856	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	1,486,868	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	53,353	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	37,909	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	686,612	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.010434	2,063,782	21,534	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950 IP RENAL DIALYSIS	0.000000	494,754	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	2,108	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		8,845,071	21,534	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			PPS Services (see inst.)	PPS Services (see inst.)
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.130229	0	33	144	0	50.00
51.00 05100 RECOVERY ROOM	0.092512	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.628293	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.020479	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.102219	0	2	8	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0.186491	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0.072852	0	0	0	0	55.00
57.00 05700 CT SCAN	0.028104	0	32	136	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.064928	0	6	25	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.096354	0	8	36	0	59.00
60.00 06000 LABORATORY	0.144203	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.040629	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0.127952	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.193116	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.158664	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.411243	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.059703	0	4	17	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.510174	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.329193	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.126538	0	925	3,978	0	73.00
74.00 07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	0	0	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0.142842	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0.810423	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0.674494	0	0	0	0	90.00
91.00 09100 EMERGENCY	0.168053	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.163300	0	0	0	0	92.00
200.00	Subtotal (see instructions)	0	1,010	4,344	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0	0	201.00
202.00	Net Charges (line 200 - line 201)		1,010	4,344	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 3:54 pm
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	4	19	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	1	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	1	4	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	2	58.00
59.00 05900 CARDIAC CATHETERIZATION	1	3	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	1	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	117	503	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.00
76.01 03950 IP RENAL DIALYSIS	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Subtotal (see instructions)	123	533	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	123	533	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of 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	42,762	0.00	6,870	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	2,359	0.00	214	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	2,296	0.00	253	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	2,167	0.00	146	41.00
43.00	04300	NURSERY	0	0	1,545	0.00	838	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	3,723	0.00	104	44.00
200.00		Total (lines 30 through 199)	0	0	54,852	0.00	8,425	200.00
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
			9.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0					30.00
31.00	03100	INTENSIVE CARE UNIT	0					31.00
40.00	04000	SUBPROVIDER - IPF	0					40.00
41.00	04100	SUBPROVIDER - IRF	0					41.00
43.00	04300	NURSERY	0					43.00
44.00	04400	SKILLED NURSING FACILITY	0					44.00
200.00		Total (lines 30 through 199)	0					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description	Title XIX				Hospital		Allied Health Cost
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01 03190 OUTPATIENT ONCOLOGY	0	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0	62.30
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	724,420	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	0	75.00
76.00 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	0	76.00
76.01 03950 I/P RENAL DIALYSIS	0	0	0	0	0	0	76.01
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	724,420	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 3:54 pm
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Cost Center Description		Title XIX			Hospital	Cost		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	72,348,558	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,282,063	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,897,183	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	13,961,848	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	42,203,615	0.000000	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0	0	0	42,983,305	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	5,798,287	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	28,881,784	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	7,893,437	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	8,836,959	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	73,424,084	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	53,911	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,251,097	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	14,727,227	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	15,292,184	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	6,669,125	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	682,585	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	24,499,208	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	652,764	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	25,194,331	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,574,386	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	724,420	724,420	69,426,854	0.010434	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	6,275,448	0.000000	76.00
76.01	03950	IP RENAL DIALYSIS	0	0	0	5,227,354	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	327,593	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	3,237,366	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	82,504,743	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	15,109,707	0.000000	92.00
200.00		Total (lines 50 through 199)	0	724,420	724,420	603,217,006		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0180

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description		Title XIX			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.000000	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.010434	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.00
76.01	03950 IP RENAL DIALYSIS	0.000000	0	0	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		42,762	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		42,762	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)		40,498	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)		9,914	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		46,604,227	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)		46,604,227	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27 46,604,227	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,089.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		10,804,773	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)		10,804,773	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1	
Date/Time Prepared: 11/28/2018 3:54 pm		Title XVIII		Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	5,431,788	2,359	2,302.58	746	1,717,725		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,333,372		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					23,855,870		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					834,402		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					610,766		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,445,168		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,410,702		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					2,264		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,089.85		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,467,420		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,312,614	46,604,227	0.071080	2,467,420	175,384	90.00
91.00	Nursing School cost	0	46,604,227	0.000000	2,467,420	0	91.00
92.00	Allied health cost	0	46,604,227	0.000000	2,467,420	0	92.00
93.00	All other Medical Education	0	46,604,227	0.000000	2,467,420	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,296 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,296 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)			2,296 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)			846 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,893,734 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,893,734 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,893,734 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			824.80 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			697,781 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)			697,781 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				169,255		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				867,036		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				38,451		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				13,914		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52,365		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)				814,671		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
56.00	Target amount (line 54 x line 55)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-S180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	104,361	1,893,734	0.055109	0	0	90.00
91.00	Nursing School cost	0	1,893,734	0.000000	0	0	91.00
92.00	Allied health cost	0	1,893,734	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,893,734	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,167 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,167 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)			2,167 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)			888 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,760,975 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,760,975 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,760,975 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			812.63 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			721,615 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)			721,615 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
					1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				543,288		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				1,264,903		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				60,615		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				21,091		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				81,706		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				1,183,197		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges				0		54.00
55.00	Target amount per discharge				0.00		55.00
56.00	Target amount (line 54 x line 55)				0		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0		57.00
58.00	Bonus payment (see instructions)				0		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0		61.00
62.00	Relief payment (see instructions)				0		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)				0		87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00		88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	147,921	1,760,975	0.083999	0	0	90.00
91.00	Nursing School cost	0	1,760,975	0.000000	0	0	91.00
92.00	Allied health cost	0	1,760,975	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,760,975	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,723	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,723	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,723	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)		2,681	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,310,049	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,310,049	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,310,049	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-5541		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm		
		Title XVIII		Skilled Nursing Facility		PPS		
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
		1.00						
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)							49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)							50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)							51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)							52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)							53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges							54.00
55.00	Target amount per discharge							55.00
56.00	Target amount (line 54 x line 55)							56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57.00
58.00	Bonus payment (see instructions)							58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket							59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket							60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61.00
62.00	Relief payment (see instructions)							62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)							63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)							64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)							65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)							66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							3,310,049 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							889.08 71.00
72.00	Program routine service cost (line 9 x line 71)							2,383,623 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							2,383,623 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)							0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							0 80.00
81.00	Inpatient routine service cost per diem limitation							0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)							2,383,623 83.00
84.00	Program inpatient ancillary services (see instructions)							1,480,661 84.00
85.00	Utilization review - physician compensation (see instructions)							0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							3,864,284 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)							0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)							0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-5541		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			42,762 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			42,762 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)			40,498 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)			6,870 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)			1,545 15.00
16.00	Nursery days (title V or XIX only)			838 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			46,604,227 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)			46,604,227 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			27 46,604,227 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,089.85 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			7,487,270 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)			7,487,270 41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm		
Cost Center Description			Title XIX		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	923,871	1,545	597.97	838	501,099	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,431,788	2,359	2,302.58	214	492,752	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,481,121	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,264	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,089.85	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,467,420	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,312,614	46,604,227	0.071080	2,467,420	175,384	90.00
91.00	Nursing School cost	0	46,604,227	0.000000	2,467,420	0	91.00
92.00	Allied health cost	0	46,604,227	0.000000	2,467,420	0	92.00
93.00	All other Medical Education	0	46,604,227	0.000000	2,467,420	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,167 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,167 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)			2,167 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)			146 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)			1,545 15.00
16.00	Nursery days (title V or XIX only)			838 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,760,975 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,760,975 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,760,975 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			812.63 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			118,644 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)			118,644 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					118,644	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XIX		Subprovider - IRF		Cost	
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	147,921	1,760,975	0.083999	0	0	90.00
91.00	Nursing School cost	0	1,760,975	0.000000	0	0	91.00
92.00	Allied health cost	0	1,760,975	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,760,975	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 3:54 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		34,714,916	30.00
31.00	03100	INTENSIVE CARE UNIT		5,118,794	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.130229	8,579,110	50.00
51.00	05100	RECOVERY ROOM	0.092512	1,456,743	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.628293	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020479	1,693,664	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102219	2,804,191	54.00
54.01	03190	OUTPATIENT ONCOLOGY	0.186491	6,952	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072852	51,774	55.00
57.00	05700	CT SCAN	0.028104	3,247,381	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.064928	590,462	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.096354	1,955,190	59.00
60.00	06000	LABORATORY	0.144203	12,215,919	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.040629	699,176	63.00
65.00	06500	RESPIRATORY THERAPY	0.127952	4,411,315	65.00
66.00	06600	PHYSICAL THERAPY	0.193116	822,705	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158664	493,017	67.00
68.00	06800	SPEECH PATHOLOGY	0.411243	161,143	68.00
69.00	06900	ELECTROCARDIOLOGY	0.059703	3,749,703	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.510174	30,208	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	5,201,734	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.329193	4,022,072	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126538	14,282,224	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	4,162	76.00
76.01	03950	IP RENAL DIALYSIS	0.142842	2,090,531	76.01
76.97	07697	CARDIAC REHABILITATION	0.810423	27,083	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.674494	13,018	90.00
91.00	09100	EMERGENCY	0.168053	6,443,784	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.163300	510,962	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		75,564,223	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		75,564,223	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		1,942,586	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.130229	7,402	964 50.00
51.00	05100 RECOVERY ROOM	0.092512	290	27 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.628293	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.020479	1,112	23 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102219	20,425	2,088 54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.186491	0	0 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.072852	0	0 55.00
57.00	05700 CT SCAN	0.028104	41,388	1,163 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.064928	3,289	214 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.096354	0	0 59.00
60.00	06000 LABORATORY	0.144203	262,805	37,897 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.040629	46	2 63.00
65.00	06500 RESPIRATORY THERAPY	0.127952	44,657	5,714 65.00
66.00	06600 PHYSICAL THERAPY	0.193116	7,658	1,479 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.158664	2,862	454 67.00
68.00	06800 SPEECH PATHOLOGY	0.411243	1,605	660 68.00
69.00	06900 ELECTROCARDIOLOGY	0.059703	52,860	3,156 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.510174	1,028	524 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	23,585	8,660 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.329193	1,847	608 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.126538	474,279	60,014 73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	0	0 76.00
76.01	03950 IP RENAL DIALYSIS	0.142842	18,540	2,648 76.01
76.97	07697 CARDIAC REHABILITATION	0.810423	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.674494	0	0 90.00
91.00	09100 EMERGENCY	0.168053	246,864	41,486 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.163300	9,024	1,474 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,221,566	169,255 200.00
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)		1,221,566	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		2,376,692	41.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.130229	162	21 50.00
51.00	05100 RECOVERY ROOM	0.092512	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.628293	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.020479	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102219	36,695	3,751 54.00
54.01	03190 OUTPATIENT ONCOLOGY	0.186491	0	0 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.072852	0	0 55.00
57.00	05700 CT SCAN	0.028104	35,668	1,002 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.064928	9,505	617 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.096354	0	0 59.00
60.00	06000 LABORATORY	0.144203	408,999	58,979 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.040629	1,896	77 63.00
65.00	06500 RESPIRATORY THERAPY	0.127952	61,037	7,810 65.00
66.00	06600 PHYSICAL THERAPY	0.193116	999,327	192,986 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.158664	616,295	97,784 67.00
68.00	06800 SPEECH PATHOLOGY	0.411243	95,772	39,386 68.00
69.00	06900 ELECTROCARDIOLOGY	0.059703	32,372	1,933 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.510174	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	89,008	32,683 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.329193	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.126538	599,955	75,917 73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0 75.00
76.00	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	0	0 76.00
76.01	03950 IP RENAL DIALYSIS	0.142842	212,416	30,342 76.01
76.97	07697 CARDIAC REHABILITATION	0.810423	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.674494	0	0 90.00
91.00	09100 EMERGENCY	0.168053	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.163300	0	0 92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,199,107	543,288 200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00	Net charges (line 200 minus line 201)		3,199,107	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.130229	0	50.00
51.00	05100	RECOVERY ROOM	0.092512	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.628293	0	52.00
53.00	05300	ANESTHESIOLOGY	0.020479	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102219	82,512	8,434
54.01	03190	OUTPATIENT ONCOLOGY	0.186491	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.072852	0	55.00
57.00	05700	CT SCAN	0.028104	15,415	433
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.064928	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.096354	0	59.00
60.00	06000	LABORATORY	0.144203	1,234,572	178,029
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.868153	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.040629	4,339	176
65.00	06500	RESPIRATORY THERAPY	0.127952	1,073,991	137,419
66.00	06600	PHYSICAL THERAPY	0.193116	1,608,856	310,696
67.00	06700	OCCUPATIONAL THERAPY	0.158664	1,486,868	235,912
68.00	06800	SPEECH PATHOLOGY	0.411243	53,353	21,941
69.00	06900	ELECTROCARDIOLOGY	0.059703	37,909	2,263
70.00	07000	ELECTROENCEPHALOGRAPHY	0.510174	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.367190	686,612	252,117
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.329193	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.126538	2,063,782	261,147
74.00	07400	RENAL DIALYSIS	0.000000	0	74.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.700108	0	76.00
76.01	03950	IP RENAL DIALYSIS	0.142842	494,754	70,672
76.97	07697	CARDIAC REHABILITATION	0.810423	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.674494	2,108	1,422
91.00	09100	EMERGENCY	0.168053	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.163300	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,845,071	1,480,661
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0
202.00		Net charges (line 200 minus line 201)		8,845,071	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	16,339,503		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0		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)	418,183		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	5,952,393		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	365.48		4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		40.45	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)		1.50	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).		19.69	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)		58.64	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		51.65	10.00
11.00	FTE count for residents in dental and podiatric programs.		3.00	11.00
12.00	Current year allowable FTE (see instructions)		54.65	12.00
13.00	Total allowable FTE count for the prior year.		47.48	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.		44.41	14.00
15.00	Sum of lines 12 through 14 divided by 3.		48.85	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		48.85	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.133660	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.146719	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.133660	21.00
22.00	IME payment adjustment (see instructions)		1,149,696	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		418,828	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-6.99	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)		1,149,696	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		418,828	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		19.60	30.00
31.00	Percentage of Medicaid patient days (see instructions)		51.39	31.00
32.00	Sum of lines 30 and 31		70.99	32.00
33.00	Allowable disproportionate share percentage (see instructions)		47.78	33.00
34.00	Disproportionate share adjustment (see instructions)		1,951,754	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)	6,766,695,164	0	35.00
35.01	Factor 3 (see instructions)	0.001262411	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	8,542,347	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	4,236,064	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	4,236,064		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	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		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	24,095,200		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
				Amount
				1.00
49.00	Total payment for inpatient operating costs (see instructions)		24,514,028	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,642,437	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).		764,600	52.00
53.00	Nursing and Allied Health Managed Care payment		1	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)		149,021	58.00
59.00	Total (sum of amounts on lines 49 through 58)		27,070,087	59.00
60.00	Primary payer payments		15,460	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		27,054,627	61.00
62.00	Deductibles billed to program beneficiaries		1,534,776	62.00
63.00	Coinurance billed to program beneficiaries		190,280	63.00
64.00	Allowable bad debts (see instructions)		209,069	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		135,895	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		32,056	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		25,465,466	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		18,370	70.93
70.94	HRR adjustment amount (see instructions)		-35,945	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			25,447,891	71.00
71.01	Sequestration adjustment (see instructions)			508,958	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			24,370,054	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)			568,879	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			315,060	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0180

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 3:54 pm

		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	16,339,503	0	16,339,503	0	16,339,503	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0	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	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	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	418,183	0	418,183	0	418,183	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	5,952,393	0	5,952,393	0	5,952,393	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.133660	0.133660	0.133660	0.133660		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,149,696	0	1,149,696	0	1,149,696	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	418,828	0	418,828	0	418,828	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
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	1,149,696	0	1,149,696	0	1,149,696	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	418,828	0	418,828	0	418,828	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4778	0.4778	0.4778	0.4778		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,951,754	0	1,951,754	0	1,951,754	11.00
11.01	Uncompensated care payments	36.00	4,236,064	0	9,138,092	2,298,846	11,436,938	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,095,200	0	21,796,354	2,298,846	24,095,200	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	24,514,028	0	22,215,182	2,298,846	24,514,028	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,642,437	0	1,642,437	0	1,642,437	16.00
17.00	Special add-on payments for new technologies	54.00	0	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	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	23,857,619	2,298,846	26,156,465	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0180

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 3:54 pm

		Title XVIII		Hospital		PPS		
	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	1,330,770	0	1,330,770	0	1,330,770	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	26,616	0	26,616	0	26,616	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	0.0595	0.0595	0.0595	0.0595		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	79,181	0	79,181	0	79,181	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1547	0.1547	0.1547	0.1547		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	205,870	0	205,870	0	205,870	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,642,437	0	1,642,437	0	1,642,437	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.		N					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0180

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2018 3:54 pm

		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	16,339,503	16,339,503		16,339,503	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	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	418,183	418,183	0	418,183	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	5,952,393	5,952,393	0	5,952,393	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.133660	0.133660	0.133660		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,149,696	1,149,696	0	1,149,696	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	418,828	418,828	0	418,828	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
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	1,149,696	1,149,696	0	1,149,696	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	418,828	418,828	0	418,828	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.4778	0.4778	0.4778		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,951,754	1,951,754	0	1,951,754	11.00
11.01	Uncompensated care payments	36.00	4,236,064	4,236,064	0	4,236,064	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	24,095,200	24,095,200	0	24,095,200	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	24,514,028	24,514,028	0	24,514,028	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,642,437	1,642,437	0	1,642,437	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	SUBTOTAL			26,156,465	0	26,156,465	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0180

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2018 3:54 pm

		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	1,330,770	1,330,770	0	1,330,770	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	26,616	26,616	0	26,616	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	0.0595	0.0595	0.0595		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	79,181	79,181	0	79,181	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1547	0.1547	0.1547		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	205,870	205,870	0	205,870	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	1,642,437	1,642,437	0	1,642,437	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	18,370	18,370	0	18,370	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	-35,945	-35,945	0	-35,945	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: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		13,462	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		10,078,695	2.00
3.00	OPPS payments		8,009,809	3.00
4.00	Outlier payment (see instructions)		65,514	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		45,789	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		13,462	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		101,957	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)		101,957	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		101,957	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		88,495	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)		13,462	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		8,121,112	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,641,723	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		6,492,851	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		258,184	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		6,751,035	30.00
31.00	Primary payer payments		461	31.00
32.00	Subtotal (line 30 minus line 31)		6,750,574	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		149,174	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		96,963	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		26,712	36.00
37.00	Subtotal (see instructions)		6,847,537	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		6,847,537	40.00
40.01	Sequestration adjustment (see instructions)		136,951	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		6,744,223	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-33,637	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,647	2.00
3.00	OPPS payments		3,626	3.00
4.00	Outlier payment (see instructions)		1,908	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		97	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		5,631	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		725	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)		4,906	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)		4,906	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		4,906	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		4,906	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment 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)		4,906	40.00
40.01	Sequestration adjustment (see instructions)		98	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		4,713	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		95	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		988	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,492	2.00
3.00	OPPS payments		1,461	3.00
4.00	Outlier payment (see instructions)		0	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		28	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		988	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		8,054	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)		8,054	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		8,054	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		7,066	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)		988	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)		1,489	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		277	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)		2,200	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)		2,200	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,200	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		2,200	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment 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)		2,200	40.00
40.01	Sequestration adjustment (see instructions)		44	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,241	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		915	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		656	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
4.01	Outlier reconciliation amount (see instructions)			4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		656	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		5,354	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)		5,354	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		5,354	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		4,698	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)		656	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)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		202	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)		454	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)		454	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		454	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		454	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.97	Demonstration payment adjustment 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)		454	40.00
40.01	Sequestration adjustment (see instructions)		9	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		535	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-90	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0180

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

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2018 3:54 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		23,380,876		6,310,935		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		989,178		433,288		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)		24,370,054		6,744,223		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		568,879		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		33,637		6.02
7.00	Total Medicare program liability (see instructions)		24,938,933		6,710,586		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-1 Part I Date/Time Prepared: 11/28/2018 3:54 pm		
		Title XVIII	Subprovider - IPF	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		753,108		4,713	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)		753,108		4,713	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		4,850		95	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		757,958		4,808	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0180 Component CCN: 14-T180		Period: From 01/01/2018 To 06/30/2018		Worksheet E-1 Part I Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider						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		1,601,249		1,241		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)		1,601,249		1,241		4.00
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0		5.01
5.02			0		0		5.02
5.03			0		0		5.03
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0		5.50
5.51			0		0		5.51
5.52			0		0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		915		6.01
6.02	SETTLEMENT TO PROGRAM		57,562		0		6.02
7.00	Total Medicare program liability (see instructions)		1,543,687		2,156		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
			0	1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet E-1 Part I Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII	Skilled Nursing Facility	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				
2.00	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		1,487,163		535
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)				
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0
3.02			0		0
3.03			0		0
3.04			0		0
3.05			0		0
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0
3.51			0		0
3.52			0		0
3.53			0		0
3.54			0		0
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0
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)		1,487,163		535
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)				
Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0
5.02			0		0
5.03			0		0
Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0
5.51			0		0
5.52			0		0
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				
6.01	SETTLEMENT TO PROVIDER		21,103		0
6.02	SETTLEMENT TO PROGRAM		0		90
7.00	Total Medicare program liability (see instructions)		1,508,266		445
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180 Component CCN: 14-S180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			816,804 1.00
2.00	Net IPF PPS Outlier Payments			30,064 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			12.685083 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			846,868 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			846,868 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			846,868 18.00
19.00	Deductibles			71,020 19.00
20.00	Subtotal (line 18 minus line 19)			775,848 20.00
21.00	Coinsurance			7,370 21.00
22.00	Subtotal (line 20 minus line 21)			768,478 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			0 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 25.00
26.00	Subtotal (sum of lines 22 and 24)			768,478 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			4,949 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			773,427 31.00
31.01	Sequestration adjustment (see instructions)			15,469 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			753,108 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			4,850 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			30,064 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part III Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			1,410,923 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0795 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			149,558 3.00
4.00	Outlier Payments			11,130 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			11.972376 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			1,571,611 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			1,571,611 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			1,571,611 19.00
20.00	Deductibles			2,680 20.00
21.00	Subtotal (line 19 minus line 20)			1,568,931 21.00
22.00	Coinsurance			0 22.00
23.00	Subtotal (line 21 minus line 22)			1,568,931 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			1,568,931 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			6,260 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			1,575,191 32.00
32.01	Sequestration adjustment (see instructions)			31,504 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			1,601,249 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-57,562 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,917 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			11,130 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180 Component CCN: 14-5541	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,676,470	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		21,534	3.00
4.00	Subtotal (sum of lines 1 through 3)		1,698,004	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		158,957	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		1,539,047	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		1,539,047	15.00
15.01	Sequestration adjustment (see instructions)		30,781	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
16.00	Interim payments		1,487,163	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)		21,103	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		8,481,121		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		8,481,121	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		8,481,121	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		8,481,121	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		8,481,121	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0180 Component CCN: 14-T180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2018 3:54 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	118,644		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	118,644	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	118,644	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	118,644	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	118,644	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0		32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 3:54 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			20.39	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			1.40	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			7.79	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			26.78	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			25.61	6.00
7.00	Enter the lesser of line 5 or line 6			25.61	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	24.15	1.46	25.61	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	24.15	1.46	25.61	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.49		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	24.15	2.95		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	21.01	1.94		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	20.37	1.48		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	21.84	2.12		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	21.84	2.12		17.00
18.00	Per resident amount	126,836.10	126,836.10		18.00
19.00	Approved amount for resident costs	2,770,100	268,893	3,038,993	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			3,038,993	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	12,394	4,232		26.00
27.00	Total Inpatient Days (see instructions)	47,624	47,624		27.00
28.00	Ratio of inpatient days to total inpatient days	0.260247	0.088863		28.00
29.00	Program direct GME amount	790,889	270,054		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		38,159		30.00
31.00	Net Program direct GME amount			1,022,784	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Hospital	PPS
		1.00		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		30,069,436	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		15,460	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		30,053,976	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		10,148,854	42.00
43.00	Primary payer payments (see instructions)		461	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		10,148,393	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		40,202,369	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.747567	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.252433	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		1,022,784	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		764,600	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		258,184	50.00

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

Provider CCN: 14-0180

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

Worksheet G

Date/Time Prepared:
11/28/2018 3:54 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,128,092	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	188,454,066	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-133,348,438	0	0	0	6.00
7.00	Inventory	5,964,215	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	3,927,349	0	0	0	9.00
10.00	Due from other funds	-561,566	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	66,563,718	0	0	0	11.00
FIXED ASSETS						
12.00	Land	35,010,000	0	0	0	12.00
13.00	Land improvements	272,750	0	0	0	13.00
14.00	Accumulated depreciation	-23,036	0	0	0	14.00
15.00	Buildings	113,680,264	0	0	0	15.00
16.00	Accumulated depreciation	-1,487,959	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	26,428,582	0	0	0	23.00
24.00	Accumulated depreciation	-1,898,712	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	171,981,889	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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	3,083,002	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,083,002	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	241,628,609	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,775,752	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	32,343,240	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	35,118,992	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	11,044	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	11,044	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	35,130,036	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	206,498,573	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	206,498,573	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	241,628,609	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0180

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

Worksheet G-1

Date/Time Prepared:
11/28/2018 3:54 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		167,716,072		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		12,915,138			2.00
3.00	Total (sum of line 1 and line 2)		180,631,210		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	OPENING BALANCE SHEET ADJ	59,167,839		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		59,167,839		0	10.00
11.00	Subtotal (line 3 plus line 10)		239,799,049		0	11.00
12.00	NET ASSET TRANSFERS	10,113,438		0		12.00
13.00	OTHER TRANSFERS	23,187,038		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		33,300,476		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		206,498,573		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	OPENING BALANCE SHEET ADJ		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	NET ASSET TRANSFERS		0			12.00
13.00	OTHER TRANSFERS		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: 14-0180

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2018 3:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	136,798,604		136,798,604	1.00
2.00	SUBPROVIDER - IPF	5,192,470		5,192,470	2.00
3.00	SUBPROVIDER - IRF	5,824,150		5,824,150	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	4,092,349		4,092,349	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)	151,907,573		151,907,573	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,111,317		14,111,317	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)	14,111,317		14,111,317	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	166,018,890		166,018,890	17.00
18.00	Ancillary services	257,032,847	348,245,009	605,277,856	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES AND 340B	0	50,888	50,888	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	423,051,737	348,295,897	771,347,634	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		150,250,583		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	ADD (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)		150,250,583		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet G-3 Date/Time Prepared: 11/28/2018 3:54 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	771,347,634	1.00
2.00	Less contractual allowances and discounts on patients' accounts	610,747,482	2.00
3.00	Net patient revenues (line 1 minus line 2)	160,600,152	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	150,250,583	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,349,569	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	9,224	6.00
7.00	Income from investments	-52,500	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	587,335	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	64,447	22.00
23.00	Governmental appropriations	0	23.00
24.00	CAPTATION AND PHYSICIAN BILLING BO	0	24.00
24.01	MISCELLANEOUS REVENUE	1,957,061	24.01
25.00	Total other income (sum of lines 6-24)	2,565,567	25.00
26.00	Total (line 5 plus line 25)	12,915,136	26.00
27.00	RECONCILING ITEM	-2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	12,915,138	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0180	Period: From 01/01/2018 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/28/2018 3:54 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,330,770	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		26,616	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)		238.46	3.00
4.00	Number of interns & residents (see instructions)		48.85	4.00
5.00	Indirect medical education percentage (see instructions)		5.95	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)		79,181	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30)(see instructions)		19.60	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		51.39	8.00
9.00	Sum of lines 7 and 8		70.99	9.00
10.00	Allowable disproportionate share percentage (see instructions)		15.47	10.00
11.00	Disproportionate share adjustment (see instructions)		205,870	11.00
12.00	Total prospective capital payments (see instructions)		1,642,437	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00