

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 9:05 am
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**PART I - COST REPORT STATUS**

Provider use only 1.  Electronically filed cost report Date: 11/28/2018 Time: 9:05 am  
 2.  Manually submitted cost report  
 3.  If this is an amended report enter the number of times the provider resubmitted this cost report  
 4.  Medicare Utilization. Enter "F" for full or "L" for low.

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

**PART II - CERTIFICATION**

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ELMHURST MEMORIAL HOSPITAL ( 14-0200 ) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	499,468	195,127	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0	0	0		0	6.00
200.00 Total	0	499,468	195,127	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200			Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 9:05 am					
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 155 E BRUSH HILL ROAD			PO Box:						1.00		
2.00	City: ELMHURST			State: IL		Zip Code: 60126		County: DUPAGE		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		ELMHURST MEMORIAL HOSPITAL		140200	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2017	06/30/2018		20.00		
21.00	Type of Control (see instructions)						2			21.00		
Inpatient PPS Information												
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (PickLe amendment hospital?) In column 2, enter "Y" for yes or "N" for no.						N	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2	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.	3,229	255	0	0	4,789	0		24.00			
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 9:05 am			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		1				26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		1				27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0				35.00
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0				36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)		N				37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						38.00
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)		N	N			39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)		N	N			40.00
		V	XVIII	XIX			
		1.00	2.00	3.00			
<b>Prospective Payment System (PPS)-Capital</b>							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N	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			46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.		N	N			47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N			48.00
<b>Teaching Hospitals</b>							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.		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				61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)			0.00			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 9:05 am		
	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>								
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						62.01	0.00
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00	N
	Program Name		Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	1.00		2.00	3.00	4.00	5.00		
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64.00	0.00 0.00 0.000000

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

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				1.00	
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00	
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00	
		V	XIX		
		1.00	2.00		
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	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	
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			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	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 9:05 am	
		1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	7,313,294	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H131	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 9:05 am			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name: EDWARD ELMHURST HEALTH	Contractor's Name: NGS		Contractor's Number: 00131			
142.00	Street: 801 SOUTH WASHINGTON STREET	PO Box:					
143.00	City: NAPERVILLE	State: IL		Zip Code: 60540			
144.00 Are provider based physicians' costs included in Worksheet A?							
				1.00	2.00		
				Y			
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.							
				1.00	2.00		
				Y			
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.							
				1.00	2.00		
				N			
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				N			
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				N			
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				N			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
155.00	Hospital	N	N	N	N		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
Multi campus							
165.00 Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				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
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							
				1.00	2.00		
				Y			
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							
				1.00	2.00		
				0			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							
				1.00	2.00		
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							
				1.00	2.00		
				9.99			
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
				1.00	2.00		
				07/01/2017	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)							
				1.00	2.00		
				N			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 9:05 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	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.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					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)	Y	11/09/2018	Y	11/09/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 9:05 am	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				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
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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	
<b>Home Office Costs</b>					
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	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY	LEONE		41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023	TONY@LEONE-CONSULTING.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 9:05 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT		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: 14-0200

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	Title V
	Line Number				Visits / Trips	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	247	90,155	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)		247	90,155	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	35	12,775	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)		282	102,930	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		282				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	26,658	2,178	56,665			1.00
2.00 HMO and other (see instructions)	8,941	4,789				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	26,658	2,178	56,665			7.00
8.00 INTENSIVE CARE UNIT	2,028	124	9,786			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		1,182	6,476			13.00
14.00 Total (see instructions)	28,686	3,484	72,927	0.00	2,020.59	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	2,020.59	27.00
28.00 Observation Bed Days		0	6,074			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	1			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	6,289	591	17,623	1.00
2.00 HMO and other (see instructions)				1,834	1,236		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		6,289	591	17,623	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
26.00 RURAL HEALTH CLINIC							26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days				0			33.00
33.01 LTCH site neutral days and discharges				0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0200

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/28/2018 9:05 am

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	131,774,645	0	131,774,645	4,202,833.00	31.35
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		268,549	0	268,549	2,640.00	101.72
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		858,223	0	858,223	8,327.00	103.07
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		40,939	0	40,939	787.00	52.02
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		2,328,737	137,101	2,465,838	97,156.00	25.38
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		4,262,685	0	4,262,685	28,418.00	150.00
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		26,336,026	0	26,336,026	695,228.00	37.88
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
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		35,441,326	0	35,441,326		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		798,261	0	798,261		
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		28,907	0	28,907		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		91,183	0	91,183		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		7,625,819	0	7,625,819		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	1,339,989	0	1,339,989	36,790.00	36.42
27.00	Administrative & General	5.00	6,552,242	0	6,552,242	205,952.00	31.81

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0200

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

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/28/2018 9:05 am

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,538,768	-58,690	2,480,078	68,983.00	35.95	30.00
31.00	Laundry & Linen Service	8.00	960,250	-78,411	881,839	58,808.00	15.00	31.00
32.00	Housekeeping	9.00	3,734,844	0	3,734,844	247,465.00	15.09	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,609,848	-1,327,196	1,282,652	68,834.00	18.63	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,327,196	1,327,196	71,225.00	18.63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,084,811	0	2,084,811	32,127.00	64.89	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	3,282,863	0	3,282,863	76,743.00	42.78	40.00
41.00	Medical Records & Medical Records Library	16.00	231,387	0	231,387	10,171.00	22.75	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: 14-0200

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

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/28/2018 9:05 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	130,875,483	0	130,875,483	4,193,719.00	31.21	1.00
2.00	Excluded area salaries (see instructions)	2,328,737	137,101	2,465,838	97,156.00	25.38	2.00
3.00	Subtotal salaries (line 1 minus line 2)	128,546,746	-137,101	128,409,645	4,096,563.00	31.35	3.00
4.00	Subtotal other wages & related costs (see inst.)	30,598,711	0	30,598,711	723,646.00	42.28	4.00
5.00	Subtotal wage-related costs (see inst.)	43,096,052	0	43,096,052	0.00	33.56	5.00
6.00	Total (sum of lines 3 thru 5)	202,241,509	-137,101	202,104,408	4,820,209.00	41.93	6.00
7.00	Total overhead cost (see instructions)	23,335,002	-137,101	23,197,901	877,098.00	26.45	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2018 9:05 am
			Amount Reported	
			1.00	
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		8,492,472	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		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
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		15,549,041	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		677,230	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		131,692	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)		1,038,762	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		116,800	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		9,594,929	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		287,927	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		470,823	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		36,359,676	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COST		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-3 Part V Date/Time Prepared: 11/28/2018 9:05 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	0	36,359,676	1.00
2.00	Hospital	0	35,441,326	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	918,350	18.00

		Outpatient		Training		Home				
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD			
		1.00	2.00	3.00	4.00	5.00	6.00			
1.00	Number of patients in program at end of cost reporting period	0	0	0	0	0	0	1.00		
2.00	Number of times per week patient receives dialysis	0.00	0.00	0.00	0.00	0.00	0.00	2.00		
3.00	Average patient dialysis time including setup	0.00	0.00	0.00	0.00			3.00		
4.00	CAPD exchanges per day				0.00		0.00	4.00		
5.00	Number of days in year dialysis furnished	0	0					5.00		
6.00	Number of stations	0	0	0	0			6.00		
7.00	Treatment capacity per day per station	0	0					7.00		
8.00	Utilization (see instructions)	0.00	0.00					8.00		
9.00	Average times dialyzers re-used	0.00	0.00					9.00		
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00		
							Y/N			
							1.00			
ESRD PPS										
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)						N		10.01	
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y		10.02	
							Prior to 1/1	After 12/31		
							1.00	2.00		
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	4	10.03	
TRANSPLANT INFORMATION										
11.00	Number of patients on transplant list						0		11.00	
12.00	Number of patients transplanted during the cost reporting period						0		12.00	
EPOETIN										
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.								13.00	
14.00	Epoetin amount from Worksheet A for Home Dialysis program								14.00	
15.00	Number of EPO units furnished relating to the renal dialysis department								15.00	
16.00	Number of EPO units furnished relating to the home dialysis department								16.00	
ARANESP										
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.								17.00	
18.00	ARANESP amount from Worksheet A for Home Dialysis program								18.00	
19.00	Number of ARANESP units furnished relating to the renal dialysis department								19.00	
20.00	Number of ARANESP units furnished relating to the home dialysis department								20.00	
							MCP	INITIAL METHOD		
							1.00	2.00		
PHYSICIAN PAYMENT METHOD										
21.00	Enter "X" if method(s) is applicable								21.00	
		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.				
		1.00	2.00	3.00	4.00	5.00				
ESAs										
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						0	0	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-5 Date/Time Prepared: 11/28/2018 9:05 am
		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-7

Date/Time Prepared:  
11/28/2018 9:05 am

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0200

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

Worksheet S-7

Date/Time Prepared:  
11/28/2018 9:05 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
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).					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)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/28/2018 9:05 am
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			1.00	
<b>Uncompensated and indigent care cost computation</b>				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.163674	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		21,842,510	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		248,819,969	6.00
7.00	Medicaid cost (line 1 times line 6)		40,725,360	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)		18,882,850	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)		18,882,850	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)	32,734,369	3,408,577	36,142,946
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,357,765	3,408,577	8,766,342
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	5,357,765	3,408,577	8,766,342
			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)		24,440,979	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		915,344	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,408,222	27.01
28.00	Non-Medicare bad debt expense (see instructions)		23,032,757	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,262,741	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		13,029,083	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		31,911,933	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0200

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

Worksheet A  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT		16,327,640		16,012,394	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		11,200,116		11,200,116	2.00
3.00	00300	OTHER CAP REL COSTS		0		0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,339,989	29,032,820	30,372,809	30,372,809	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,552,242	114,074,254	120,626,496	117,240,451	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	2,538,768	14,116,015	16,654,783	17,347,658	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	960,250	945,219	1,905,469	1,825,175	8.00
9.00	00900	HOUSEKEEPING	3,734,844	1,036,157	4,771,001	4,771,001	9.00
10.00	01000	DIETARY	2,609,848	1,527,523	4,137,371	2,033,378	10.00
11.00	01100	CAFETERIA	0	0	0	2,103,993	11.00
13.00	01300	NURSING ADMINISTRATION	2,084,811	34,959	2,119,770	2,119,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	3,282,863	35,953,683	39,236,546	4,116,735	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	231,387	529	231,916	231,916	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	398,733	26,058	424,791	424,791	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	22,337,000	2,285,864	24,622,864	23,323,288	30.00
31.00	03100	INTENSIVE CARE UNIT	6,207,914	923,970	7,131,884	6,249,181	31.00
43.00	04300	NURSERY	1,194,074	63,003	1,257,077	2,369,985	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	12,769,733	47,192,030	59,961,763	19,269,861	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,511,418	783,173	4,294,591	2,939,195	52.00
53.00	05300	ANESTHESIOLOGY	175,226	727,802	903,028	492,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,450,181	3,322,413	7,772,594	4,228,809	54.00
54.01	03630	ULTRASOUND	1,429,764	193,304	1,623,068	1,571,900	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,545,864	1,631,825	4,177,689	4,131,077	55.00
55.01	05501	CYBERKNI FE	537,668	2,502,017	3,039,685	3,085,328	55.01
56.00	05600	RADIOISOTOPE	574,114	1,798,443	2,372,557	2,380,776	56.00
57.00	05700	CT SCAN	1,034,791	885,222	1,920,013	1,525,478	57.00
58.00	05800	MRI	796,441	287,707	1,084,148	1,046,984	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,819,199	8,524,329	10,343,528	1,934,649	59.00
60.00	06000	LABORATORY	7,407,979	12,064,108	19,472,087	12,098,916	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,847,495	639,495	2,486,990	2,195,772	65.00
65.01	03610	SLEEP LAB	448,282	56,722	505,004	481,862	65.01
66.00	06600	PHYSICAL THERAPY	3,494,471	47,214	3,541,685	3,472,003	66.00
67.00	06700	OCCUPATIONAL THERAPY	688,810	6,863	695,673	743,957	67.00
68.00	06800	SPEECH PATHOLOGY	253,255	1,142	254,397	254,355	68.00
69.00	06900	ELECTROCARDIOLOGY	879,680	2,068,292	2,947,972	2,725,834	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	339,244	17,555	356,799	339,641	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	30,071,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	37,791,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	35,119,811	73.00
74.00	07400	RENAL DIALYSIS	0	868,712	868,712	868,353	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	455,705	15,110	470,815	464,131	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	22,298,400	12,922,531	35,220,931	34,512,693	90.00
90.01	09001	OUTPATIENT CLINICS	2,480,922	1,371,629	3,852,551	3,525,668	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	498,698	90.02
91.00	09100	EMERGENCY	6,133,276	1,934,500	8,067,776	7,406,464	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	129,844,641	327,409,948	457,254,589	456,920,410	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	368,955	710,649	1,079,604	1,079,604	190.00
190.01	19001	FOUNDATION	394,332	15,176	409,508	409,508	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	958,302	958,302	1,292,481	192.00
192.01	19201	SCHOOL NURSES	1,027,576	0	1,027,576	1,027,576	192.01
194.00	07950	OUTPATIENT PHARMACY	139,141	652,790	791,931	791,931	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	131,774,645	329,746,865	461,521,510	461,521,510	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0200

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

Worksheet A  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,214,906	21,227,300	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,283,473	12,483,589	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,459,016	39,831,825	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-39,510,371	77,730,080	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-565,526	16,782,132	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-1,195,179	629,996	8.00
9.00	00900	HOUSEKEEPING	-48,310	4,722,691	9.00
10.00	01000	DIETARY	0	2,033,378	10.00
11.00	01100	CAFETERIA	-1,553,407	550,586	11.00
13.00	01300	NURSING ADMINISTRATION	-100,538	2,019,232	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
15.00	01500	PHARMACY	253,418	4,370,153	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,418,411	2,650,327	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	-3,375	421,416	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-455,193	22,868,095	30.00
31.00	03100	INTENSIVE CARE UNIT	-3,815	6,245,366	31.00
43.00	04300	NURSERY	0	2,369,985	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-1,436,636	17,833,225	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,939,195	52.00
53.00	05300	ANESTHESIOLOGY	0	492,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-147,403	4,081,406	54.00
54.01	03630	ULTRASOUND	0	1,571,900	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,285,046	2,846,031	55.00
55.01	05501	CYBERKNIFE	-427,314	2,658,014	55.01
56.00	05600	RADIOISOTOPE	0	2,380,776	56.00
57.00	05700	CT SCAN	0	1,525,478	57.00
58.00	05800	MRI	0	1,046,984	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,934,649	59.00
60.00	06000	LABORATORY	-6,454,417	5,644,499	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,195,772	65.00
65.01	03610	SLEEP LAB	0	481,862	65.01
66.00	06600	PHYSICAL THERAPY	-18,377	3,453,626	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	743,957	67.00
68.00	06800	SPEECH PATHOLOGY	0	254,355	68.00
69.00	06900	ELECTROCARDIOLOGY	-1,807,876	917,958	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	339,641	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	30,071,185	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	37,791,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	35,119,811	73.00
74.00	07400	RENAL DIALYSIS	0	868,353	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	464,131	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	-5,178,522	29,334,171	90.00
90.01	09001	OUTPATIENT CLINICS	-953,901	2,571,767	90.01
90.02	09003	OUTPATIENT SERVICES	0	498,698	90.02
91.00	09100	EMERGENCY	-417,156	6,989,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-42,933,138	413,987,272	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,079,604	190.00
190.01	19001	FOUNDATION	0	409,508	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,292,481	192.00
192.01	19201	SCHOOL NURSES	0	1,027,576	192.01
194.00	07950	OUTPATIENT PHARMACY	0	791,931	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-42,933,138	418,588,372	200.00

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6

Date/Time Prepared:  
11/28/2018 9:05 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
<b>A - CAFETERIA</b>					
1.00	CAFETERIA	11.00	1,327,196	776,797	1.00
	TOTALS		1,327,196	776,797	
<b>C - DRUGS SOLD</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	35,119,811	1.00
	TOTALS		0	35,119,811	
<b>D - RADIOLOGY SUPPORT</b>					
1.00	ULTRASOUND	54.01	98,453	843	1.00
2.00	RADIOLOGY-THERAPEUTIC	55.00	175,306	7,116	2.00
3.00	CYBERKNIFE	55.01	37,023	10,910	3.00
4.00	RADIOISOTOPE	56.00	39,533	7,842	4.00
5.00	CT SCAN	57.00	71,255	3,860	5.00
6.00	MRI	58.00	54,842	1,255	6.00
	TOTALS		476,412	31,826	
<b>E - CHARGEABLE SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	30,071,185	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	90,752	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
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
	TOTALS		0	30,161,937	
<b>F - LABOR &amp; DELIVERY R &amp; B PORTION</b>					
1.00	ADULTS & PEDIATRICS	30.00	1,108,222	247,174	1.00
	TOTALS		1,108,222	247,174	
<b>G - NURSERY</b>					
1.00	NURSERY	43.00	702,705	52,299	1.00
	TOTALS		702,705	52,299	
<b>I - REHAB ADMIN</b>					
1.00	OCCUPATIONAL THERAPY	67.00	50,889	1,675	1.00
2.00	SPEECH PATHOLOGY	68.00	18,710	279	2.00
	TOTALS		69,599	1,954	
<b>J - IMPLANTS</b>					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	37,791,491	1.00
2.00	RADIOISOTOPE	56.00	0	9,659	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
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
	TOTALS		0	37,801,150	

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6

Date/Time Prepared:  
11/28/2018 9:05 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>K - LOMBARD POB COSTS</b>					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	109,824	82,944	1.00
2.00		0.00	0	0	2.00
	<b>TOTALS</b>		109,824	82,944	
<b>L - POB BUILDING COSTS</b>					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	27,277	114,134	1.00
2.00		0.00	0	0	2.00
3.00	OPERATION OF PLANT	7.00	0	832,626	3.00
	<b>TOTALS</b>		27,277	946,760	
<b>M - PHYSICIAN FEES</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	1,133,389	1.00
2.00	NURSERY	43.00	0	408,625	2.00
3.00	OPERATING ROOM	50.00	0	343,580	3.00
4.00	EMERGENCY	91.00	0	601,504	4.00
5.00	RESPIRATORY THERAPY	65.00	0	61,049	5.00
6.00	CLINIC	90.00	0	297,136	6.00
	<b>TOTALS</b>		0	2,845,283	
<b>N - INTEREST EXP TO LINE 1</b>					
1.00		0.00	0	0	1.00
	<b>TOTALS</b>		0	0	
<b>O - OUTPATIENT SERVICE RECLASS</b>					
1.00	OUTPATIENT SERVICES	90.02	452,030	46,668	1.00
	<b>TOTALS</b>		452,030	46,668	
500.00	<b>Grand Total: Increases</b>		4,273,265	108,114,603	500.00

RECLASSIFICATIONS

Provider CCN: 14-0200

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

Worksheet A-6  
Date/Time Prepared:  
11/28/2018 9:05 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - CAFETERIA</b>						
1.00	DIETARY	10.00	1,327,196	776,797	0	1.00
	TOTALS		1,327,196	776,797		
<b>C - DRUGS SOLD</b>						
1.00	PHARMACY	15.00	0	35,119,811	0	1.00
	TOTALS		0	35,119,811		
<b>D - RADIOLOGY SUPPORT</b>						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	476,412	31,826	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	TOTALS		476,412	31,826		
<b>E - CHARGEABLE SUPPLIES</b>						
1.00	ADULTS & PEDIATRICS	30.00	0	2,430,582	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	875,868	0	2.00
3.00	NURSERY	43.00	0	50,371	0	3.00
4.00	OPERATING ROOM	50.00	0	9,581,526	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	409,731	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,658,135	0	6.00
7.00	ULTRASOUND	54.01	0	149,405	0	7.00
8.00	RADIOLOGY-THERAPEUTIC	55.00	0	229,034	0	8.00
9.00	CYBERKNIFE	55.01	0	2,290	0	9.00
10.00	RADIOISOTOPE	56.00	0	48,815	0	10.00
11.00	CT SCAN	57.00	0	459,875	0	11.00
12.00	MRI	58.00	0	93,261	0	12.00
13.00	CARDIAC CATHETERIZATION	59.00	0	2,622,757	0	13.00
14.00	LABORATORY	60.00	0	7,372,910	0	14.00
15.00	RESPIRATORY THERAPY	65.00	0	352,267	0	15.00
16.00	SLEEP LAB	65.01	0	23,142	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	17,118	0	17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	4,280	0	18.00
19.00	SPEECH PATHOLOGY	68.00	0	42	0	19.00
20.00	ELECTROCARDIOLOGY	69.00	0	222,138	0	20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	17,158	0	21.00
22.00	RENAL DIALYSIS	74.00	0	359	0	22.00
23.00	CARDIAC REHABILITATION	76.97	0	6,684	0	23.00
24.00	CLINIC	90.00	0	991,795	0	24.00
25.00	OUTPATIENT CLINICS	90.01	0	320,859	0	25.00
26.00	EMERGENCY	91.00	0	1,221,535	0	26.00
27.00	ELECTROENCEPHALOGRAPHY		0	0	0	27.00
29.00	CARDIAC REHABILITATION		0	0	0	29.00
30.00	CLINIC		0	0	0	30.00
31.00	OUTPATIENT CLINICS		0	0	0	31.00
32.00	EMERGENCY		0	0	0	32.00
	TOTALS		0	30,161,937		
<b>F - LABOR &amp; DELIVERY R &amp; B PORTION</b>						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,108,222	247,174	0	1.00
	TOTALS		1,108,222	247,174		
<b>G - NURSERY</b>						
1.00	ADULTS & PEDIATRICS	30.00	702,705	52,299	0	1.00
	TOTALS		702,705	52,299		
<b>I - REHAB ADMIN</b>						
1.00	PHYSICAL THERAPY	66.00	50,889	1,675	0	1.00
2.00	SPEECH PATHOLOGY	68.00	18,710	279	0	2.00
	TOTALS		69,599	1,954		
<b>J - IMPLANTS</b>						
1.00	ADULTS & PEDIATRICS	30.00	0	104,077	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	6,835	0	2.00
3.00	NURSERY	43.00	0	350	0	3.00
4.00	OPERATING ROOM	50.00	0	31,453,956	0	4.00
5.00	ANESTHESIOLOGY	53.00	0	419	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	377,412	0	6.00
7.00	ULTRASOUND	54.01	0	1,059	0	7.00
9.00	CT SCAN	57.00	0	9,775	0	9.00
10.00	CARDIAC CATHETERIZATION	59.00	0	5,786,122	0	10.00
11.00	LABORATORY	60.00	0	261	0	11.00
12.00	CLINIC	90.00	0	13,579	0	12.00
13.00	OUTPATIENT CLINICS	90.01	0	6,024	0	13.00
14.00	EMERGENCY	91.00	0	41,281	0	14.00
	TOTALS		0	37,801,150		

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>K - LOMBARD POB COSTS</b>							
1.00	OPERATION OF PLANT	7.00	31,413	81,061	0		1.00
2.00	LAUNDRY & LINEN SERVICE	8.00	78,411	1,883	0		2.00
	TOTALS		109,824	82,944			
<b>L - POB BUILDING COSTS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	315,246	9		1.00
2.00	OPERATION OF PLANT	7.00	27,277	0	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	631,514	0		3.00
	TOTALS		27,277	946,760			
<b>M - PHYSICIAN FEES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,845,283	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		0	2,845,283			
<b>N - INTEREST EXP TO LINE 1</b>							
1.00		0.00	0	0	11		1.00
	TOTALS		0	0			
<b>O - OUTPATIENT SERVICE RECLASS</b>							
1.00	ADULTS & PEDIATRICS	30.00	452,030	46,668	0		1.00
	TOTALS		452,030	46,668			
500.00	Grand Total: Decreases		4,273,265	108,114,603			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

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

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	31,291,794	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	459,219,881	6,379,926	0	6,379,926	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	221,823,809	7,131,532	0	7,131,532	32,000	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	712,335,484	13,511,458	0	13,511,458	32,000	8.00
9.00	Reconciling Items	71	0	0	0	1	9.00
10.00	Total (line 8 minus line 9)	712,335,413	13,511,458	0	13,511,458	31,999	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	31,291,794	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	465,599,807	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	228,923,341	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	725,814,942	0				8.00
9.00	Reconciling Items	70	0				9.00
10.00	Total (line 8 minus line 9)	725,814,872	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

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

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	16,327,640	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	11,200,116	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	27,527,756	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	16,327,640				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	11,200,116				2.00
3.00	Total (sum of lines 1-2)	0	27,527,756				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0200

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

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/28/2018 9:05 am

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	496,891,143	0	496,891,143	0.684598	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	228,923,728	0	228,923,728	0.315402	0	2.00
3.00	Total (sum of lines 1-2)	725,814,871	0	725,814,871	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	16,012,394	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	12,483,589	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	28,495,983	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	5,214,906	0	0	0	21,227,300	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	12,483,589	2.00
3.00	Total (sum of lines 1-2)	5,214,906	0	0	0	33,710,889	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0200

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

Worksheet A-8

Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			3.00	4.00		
	1.00	2.00		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)	A	-39,843		ADMINISTRATIVE & GENERAL	5.00	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	-7,726,155				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	-22,241,265				0 12.00
13.00 Laundry and linen service			0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-1,553,407		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)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0200

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

Worksheet A-8

Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			1.00	2.00		3.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.00
33.01 OTHER OPERATING REVENUE	B	1	ADMINISTRATIVE & GENERAL		5.00	0 33.01
33.02 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.02
33.03 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.03
33.04 PATIENT PHONE DEPRECIATION	A	-3,990	CAP REL COSTS-MVBLE EQUIP		2.00	9 33.04
33.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.05
33.06 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.06
33.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.07
33.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.08
33.09 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 33.09
33.10 PENSION INCOME CREDITED TO EXPENSE	A	3,153,257	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.10
34.00 DONATIONS	A	-144,268	ADMINISTRATIVE & GENERAL		5.00	0 34.00
35.00 PHYSICIAN PROFESSIONAL COMPONENT	A	0	PHYSICIANS' PRIVATE OFFICES		192.00	0 35.00
36.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.00
36.01 OTHER REVENUE	B	10,753	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 36.01
36.02 OTHER REVENUE	B	-4,573,815	ADMINISTRATIVE & GENERAL		5.00	0 36.02
36.03 OTHER REVENUE	B	-565,526	OPERATION OF PLANT		7.00	0 36.03
36.04 OTHER REVENUE	B	-1,195,179	LAUNDRY & LINEN SERVICE		8.00	0 36.04
36.05 OTHER REVENUE	B	-48,310	HOUSEKEEPING		9.00	0 36.05
36.06 OTHER REVENUE	B	-3,375	PARAMED ED PRGM-PASTORAL CARE		23.00	0 36.06
36.07 OTHER REVENUE	B	-100,538	NURSING ADMINISTRATION		13.00	0 36.07
36.08 OTHER REVENUE	B	-1,550	PHARMACY		15.00	0 36.08
36.09 OTHER REVENUE	B	-332,451	ADULTS & PEDIATRICS		30.00	0 36.09
36.10 OTHER REVENUE	B	-3,815	INTENSIVE CARE UNIT		31.00	0 36.10
36.11 OTHER REVENUE	B	-147,403	RADIOLOGY-DIAGNOSTIC		54.00	0 36.11
36.12 OTHER REVENUE	B	-427,314	CYBERKNI FE		55.01	0 36.12
36.13 OTHER REVENUE	B	-5,762,051	LABORATORY		60.00	0 36.13
36.14 OTHER REVENUE	B	-18,377	PHYSICAL THERAPY		66.00	0 36.14
36.15 OTHER REVENUE	B	-1,136,279	CLINIC		90.00	0 36.15
36.16 OTHER REVENUE	B	-72,238	OUTPATIENT CLINICS		90.01	0 36.16
36.17 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.17
36.18 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.18
36.19 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.19
36.20 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.20
36.21 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.21
36.22 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.22
36.23 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0 36.23
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-42,933,138				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: 14-0200  
 Period: From 07/01/2017 To 06/30/2018  
 Worksheet A-8-1  
 Date/Time Prepared: 11/28/2018 9:05 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00		0	0	1.00	
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	DEPRECIATION EXPENSE	1,287,463	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	BENEFITS	6,295,006	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	A & G	48,476,554	80,590,433	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE	7,313,294	5,369,434	3.02
3.03	15.00	PHARMACY	RX	254,968	0	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	2,418,411	0	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY PHYSICIAN SERV	0	4,403,162	3.05
3.06	50.00	OPERATING ROOM	RELATED PARTY PHYSICIAN SERV	0	1,436,636	3.06
3.07	55.00	RADIOLOGY-THERAPEUTIC	RELATED PARTY PHYSICIAN SERV	0	1,285,046	3.07
3.08	91.00	EMERGENCY	RELATED PARTY PHYSICIAN SERV	0	417,156	3.08
3.09	0.00			0	0	3.09
4.00	0.00			0	0	4.00
4.01	1.00	CAP REL COSTS-BLDG & FIXT	ELMHURST HEALTHCARE LOSS ON	5,214,906	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			71,260,602	93,501,867	5.00

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

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

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

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

6.00	B	EDWARD ELMHURST HEALTH	100.00	0.00	6.00
7.00	B	ELMHURST MEMORI	100.00	0.00	7.00
8.00	C	EDWARD HEALTH V	100.00	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: 14-0200

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

Worksheet A-8-1

Date/Time Prepared:  
11/28/2018 9:05 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	0	0		1.00
2.00	1,287,463	9		2.00
3.00	6,295,006	0		3.00
3.01	-32,113,879	0		3.01
3.02	1,943,860	0		3.02
3.03	254,968	0		3.03
3.04	2,418,411	0		3.04
3.05	-4,403,162	0		3.05
3.06	-1,436,636	0		3.06
3.07	-1,285,046	0		3.07
3.08	-417,156	0		3.08
3.09	0	0		3.09
4.00	0	0		4.00
4.01	5,214,906	11		4.01
5.00	-22,241,265			5.00

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

Related Organization(s) and/or Home Office	Type of Business		
	6.00		

**B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:**

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
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: 14-0200

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

Worksheet A-8-2

Date/Time Prepared:  
11/28/2018 9:05 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	556,508	0	556,508	211,500	3,710	1.00
2.00	60.00	LABORATORY	692,366	692,366	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	1,807,876	1,807,876	0	0	0	3.00
4.00	90.00	CLINIC	3,926,213	3,012,399	913,814	211,500	6,092	4.00
5.00	90.01	OUTPATIENT CLINICS	881,663	881,663	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	122,742	122,742	0	0	0	7.00
8.00	90.00	CLINIC	735,481	735,481	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			8,722,849	7,252,527	1,470,322		9,802	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	377,243	18,862	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	619,451	30,973	0	0	0	4.00
5.00	90.01	OUTPATIENT CLINICS	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			996,694	49,835	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	377,243	179,265	179,265	1.00
2.00	60.00	LABORATORY	0	0	0	692,366	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	1,807,876	3.00
4.00	90.00	CLINIC	0	619,451	294,363	3,306,762	4.00
5.00	90.01	OUTPATIENT CLINICS	0	0	0	881,663	5.00
6.00	0.00		0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	122,742	7.00
8.00	90.00	CLINIC	0	0	0	735,481	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	996,694	473,628	7,726,155	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	21,227,300	21,227,300			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	12,483,589		12,483,589		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	39,831,825	190,328	8,593	40,030,746	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	77,730,080	2,764,452	2,581,359	2,010,903	85,086,794
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	16,782,132	1,099,686	6,625,530	761,143	25,268,491
8.00 00800	LAUNDRY & LINEN SERVICE	629,996	52,354	23,694	270,639	976,683
9.00 00900	HOUSEKEEPING	4,722,691	48,376	10,535	1,146,235	5,927,837
10.00 01000	DIETARY	2,033,378	412,350	72,063	393,650	2,911,441
11.00 01100	CAFETERIA	550,586	578,329	0	407,320	1,536,235
13.00 01300	NURSING ADMINISTRATION	2,019,232	28,294	1,372	639,835	2,688,733
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	4,370,153	80,584	42,553	1,007,521	5,500,811
16.00 01600	MEDICAL RECORDS & LIBRARY	2,650,327	58,609	12,423	71,013	2,792,372
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
23.00 02300	PARAMED PRGM-PASTORAL CARE	421,416	83,407	37	122,372	627,232
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	22,868,095	7,126,368	377,206	6,841,017	37,212,686
31.00 03100	INTENSIVE CARE UNIT	6,245,366	1,005,500	41,400	1,905,227	9,197,493
43.00 04300	NURSERY	2,369,985	0	0	582,127	2,952,112
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	17,833,225	2,026,206	745,695	3,919,069	24,524,195
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,939,195	0	81,851	737,548	3,758,594
53.00 05300	ANESTHESIOLOGY	492,878	12,703	29,441	53,777	588,799
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,081,406	596,839	216,709	1,219,562	6,114,516
54.01 03630	ULTRASOUND	1,571,900	58,000	47,091	469,014	2,146,005
55.00 05500	RADIOLOGY-THERAPEUTIC	2,846,031	965,593	376,096	835,135	5,022,855
55.01 05501	CYBERKNIFE	2,658,014	0	83	176,374	2,834,471
56.00 05600	RADIOISOTOPE	2,380,776	133,066	11,383	188,330	2,713,555
57.00 05700	CT SCAN	1,525,478	86,069	44,935	339,449	1,995,931
58.00 05800	MRI	1,046,984	89,053	155,956	261,261	1,553,254
59.00 05900	CARDIAC CATHETERIZATION	1,934,649	400,866	181,835	558,318	3,075,668
60.00 06000	LABORATORY	5,644,499	942,945	185,516	2,273,531	9,046,491
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	2,195,772	202,614	11,395	567,002	2,976,783
65.01 03610	SLEEP LAB	481,862	0	43,174	137,579	662,615
66.00 06600	PHYSICAL THERAPY	3,453,626	51,712	12,598	1,056,846	4,574,782
67.00 06700	OCCUPATIONAL THERAPY	743,957	51,648	1,259	227,016	1,023,880
68.00 06800	SPEECH PATHOLOGY	254,355	0	0	77,725	332,080
69.00 06900	ELECTROCARDIOLOGY	917,958	360,028	34,195	269,976	1,582,157
70.00 07000	ELECTROENCEPHALOGRAPHY	339,641	0	587	104,115	444,343
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,071,185	0	0	0	30,071,185
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	37,791,491	0	0	0	37,791,491
73.00 07300	DRUGS CHARGED TO PATIENTS	35,119,811	0	0	0	35,119,811
74.00 07400	RENAL DIALYSIS	868,353	28,230	225	0	896,808
76.00 03020	CARDIAC REHABILITATION	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	464,131	0	26,508	139,857	630,496
76.98 07698	HYPERBARIIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	29,334,171	0	392,146	6,843,407	36,569,724
90.01 09001	OUTPATIENT CLINICS	2,571,767	0	44,997	761,402	3,378,166
90.02 09003	OUTPATIENT SERVICES	498,698	164,632	0	138,729	802,059
91.00 09100	EMERGENCY	6,989,308	1,059,297	36,388	1,882,321	9,967,314
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	413,987,272	20,758,138	12,476,828	39,396,345	412,876,948
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	1,079,604	211,981	6,761	113,233	1,411,579
190.01 19001	FOUNDATION	409,508	0	0	121,022	530,530
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,292,481	257,181	0	42,077	1,591,739
192.01 19201	SCHOOL NURSES	1,027,576	0	0	315,366	1,342,942
194.00 07950	OUTPATIENT PHARMACY	791,931	0	0	42,703	834,634
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	418,588,372	21,227,300	12,483,589	40,030,746	418,588,372

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	85,086,794				5.00	
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00	
7.00	00700	OPERATION OF PLANT	6,446,801	0	31,715,292		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	249,183	0	96,688	1,322,554	8.00	
9.00	00900	HOUSEKEEPING	1,512,381	0	89,342	9,999	7,539,559	9.00
10.00	01000	DIETARY	742,802	0	761,540	0	182,106	10.00
11.00	01100	CAFETERIA	391,943	0	1,068,076	0	255,408	11.00
13.00	01300	NURSING ADMINISTRATION	685,982	0	52,254	0	12,496	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	1,403,433	0	148,824	0	35,588	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	712,423	0	108,241	0	25,884	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	160,027	0	154,038	0	36,835	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	9,494,147	0	13,161,184	261,098	3,147,222	30.00
31.00	03100	INTENSIVE CARE UNIT	2,346,575	0	1,856,987	69,114	444,059	31.00
43.00	04300	NURSERY	753,178	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	6,256,907	0	3,742,056	124,662	894,834	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	958,938	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	150,221	0	23,461	0	5,610	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,560,009	0	1,102,260	49,414	263,582	54.00
54.01	03630	ULTRASOUND	547,515	0	107,116	736	25,614	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,281,491	0	1,783,286	1,909	426,435	55.00
55.01	05501	CYBERKNIFE	723,164	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	692,315	0	245,750	9,654	58,766	56.00
57.00	05700	CT SCAN	509,226	0	158,955	6,459	38,011	57.00
58.00	05800	MRI	396,285	0	164,465	16,919	39,328	58.00
59.00	05900	CARDIAC CATHETERIZATION	784,701	0	740,330	17,946	177,034	59.00
60.00	06000	LABORATORY	2,308,049	0	1,741,458	234	416,433	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	759,473	0	374,194	0	89,481	65.00
65.01	03610	SLEEP LAB	169,054	0	0	3,236	0	65.01
66.00	06600	PHYSICAL THERAPY	1,167,173	0	95,504	2,780	22,838	66.00
67.00	06700	OCCUPATIONAL THERAPY	261,225	0	95,385	0	22,809	67.00
68.00	06800	SPEECH PATHOLOGY	84,724	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	403,659	0	664,911	0	158,999	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	113,366	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,672,122	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,641,686	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,960,188	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	228,804	0	52,136	1,532	12,467	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	160,860	0	0	383	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	9,330,107	0	0	11,861	0	90.00
90.01	09001	OUTPATIENT CLINICS	861,878	0	0	14,852	0	90.01
90.02	09003	OUTPATIENT SERVICES	204,631	0	304,047	6,032	72,706	90.02
91.00	09100	EMERGENCY	2,542,981	0	1,956,341	121,150	467,818	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	83,629,627	0	30,848,829	729,970	7,332,363	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	360,139	0	391,493	7,178	93,617	190.00
190.01	19001	FOUNDATION	135,355	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	406,104	0	474,970	585,406	113,579	192.00
192.01	19201	SCHOOL NURSES	342,627	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	212,942	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	85,086,794	0	31,715,292	1,322,554	7,539,559	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/28/2018 9:05 am
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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	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	4,597,889					10.00
11.00	01100	0	3,251,662				11.00
13.00	01300	0	30,306	3,469,771			13.00
14.00	01400	0	0	0	0		14.00
15.00	01500	0	72,393	0	0	7,161,049	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	0	15,735	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	4,123,176	631,310	1,410,644	0	97	30.00
31.00	03100	474,713	162,238	362,516	0	515	31.00
43.00	04300	0	45,701	102,117	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	370,557	827,999	0	3,589	50.00
52.00	05200	0	88,423	0	0	67	52.00
53.00	05300	0	8,036	17,198	0	49,455	53.00
54.00	05400	0	127,251	0	0	0	54.00
54.01	03630	0	32,667	0	0	144	54.01
55.00	05500	0	60,682	135,591	0	0	55.00
55.01	05501	0	10,111	0	0	0	55.01
56.00	05600	0	12,224	0	0	281,211	56.00
57.00	05700	0	23,925	0	0	20,453	57.00
58.00	05800	0	17,560	0	0	172	58.00
59.00	05900	0	31,971	0	0	15	59.00
60.00	06000	0	255,441	0	0	155,653	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	54,109	0	0	0	65.00
65.01	03610	0	12,973	0	0	0	65.01
66.00	06600	0	83,496	0	0	0	66.00
67.00	06700	0	15,368	0	0	1	67.00
68.00	06800	0	5,318	0	0	0	68.00
69.00	06900	0	23,013	0	0	18	69.00
70.00	07000	0	6,766	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	5,625,742	73.00
74.00	07400	0	0	0	0	1	74.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	0	13,026	29,107	0	1	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	710,528	0	0	904,238	90.00
90.01	09001	0	58,634	131,015	0	2,765	90.01
90.02	09003	0	13,472	38,288	0	0	90.02
91.00	09100	0	187,769	415,296	0	13,583	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		4,597,889	3,181,003	3,469,771	0	7,057,720	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	18,930	0	0	0	190.00
190.01	19001	0	10,809	0	0	0	190.01
192.00	19200	0	2,150	0	0	0	192.00
192.01	19201	0	38,770	0	0	0	192.01
194.00	07950	0	0	0	0	103,329	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		4,597,889	3,251,662	3,469,771	0	7,161,049	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM-PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	23.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,638,920					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	0	993,867			23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	305,738	0	576,883	70,324,185	0	30.00
31.00	03100	INTENSIVE CARE UNIT	62,641	0	156,761	15,133,612	0	31.00
43.00	04300	NURSERY	31,891	0	0	3,884,999	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	319,766	0	0	37,064,565	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	33,229	0	0	4,839,251	0	52.00
53.00	05300	ANESTHESIOLOGY	137,763	0	0	980,543	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	133,821	0	0	9,350,853	0	54.00
54.01	03630	ULTRASOUND	47,072	0	0	2,906,869	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	73,635	0	0	8,785,884	0	55.00
55.01	05501	CYBERKNIFE	21,765	0	0	3,589,511	0	55.01
56.00	05600	RADIOISOTOPE	35,039	0	0	4,048,514	0	56.00
57.00	05700	CT SCAN	220,564	0	0	2,973,524	0	57.00
58.00	05800	MRI	90,761	0	0	2,278,744	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	100,211	0	0	4,927,876	0	59.00
60.00	06000	LABORATORY	351,135	0	0	14,274,894	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	51,780	0	0	4,305,820	0	65.00
65.01	03610	SLEEP LAB	12,622	0	0	860,500	0	65.01
66.00	06600	PHYSICAL THERAPY	41,588	0	0	5,988,161	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,960	0	0	1,429,628	0	67.00
68.00	06800	SPEECH PATHOLOGY	3,864	0	0	425,986	0	68.00
69.00	06900	ELECTROCARDIOLOGY	42,507	0	0	2,875,264	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,983	0	0	572,458	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	164,874	0	0	37,908,181	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	213,755	0	0	47,646,932	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	651,883	0	0	50,357,624	0	73.00
74.00	07400	RENAL DIALYSIS	5,689	0	0	1,197,437	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	10,441	0	0	844,314	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	140,117	0	0	47,666,575	0	90.00
90.01	09001	OUTPATIENT CLINICS	18,756	0	103,462	4,569,528	0	90.01
90.02	09003	OUTPATIENT SERVICES	7,167	0	0	1,448,402	0	90.02
91.00	09100	EMERGENCY	289,903	0	156,761	16,118,916	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,638,920	0	993,867	409,579,550	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	2,282,936	0	190.00
190.01	19001	FOUNDATION	0	0	0	676,694	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	3,173,948	0	192.00
192.01	19201	SCHOOL NURSES	0	0	0	1,724,339	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	1,150,905	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,638,920	0	993,867	418,588,372	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0200

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

Worksheet B  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
43.00	04300	NURSERY	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03630	ULTRASOUND	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
55.01	05501	CYBERKNIFE	55.01
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	03610	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.00	03020	CARDIAC REHABILITATION	76.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000	CLINIC	90.00
90.01	09001	OUTPATIENT CLINICS	90.01
90.02	09003	OUTPATIENT SERVICES	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
190.01	19001	FOUNDATION	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	SCHOOL NURSES	192.01
194.00	07950	OUTPATIENT PHARMACY	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	190,328	8,593	198,921	198,921
5.00 00500	ADMINISTRATIVE & GENERAL	231,768	2,764,452	2,581,359	5,577,579	9,992
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	0	1,099,686	6,625,530	7,725,216	3,782
8.00 00800	LAUNDRY & LINEN SERVICE	300	52,354	23,694	76,348	1,345
9.00 00900	HOUSEKEEPING	0	48,376	10,535	58,911	5,696
10.00 01000	DIETARY	4,729	412,350	72,063	489,142	1,956
11.00 01100	CAFETERIA	0	578,329	0	578,329	2,024
13.00 01300	NURSING ADMINISTRATION	0	28,294	1,372	29,666	3,179
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	567,016	80,584	42,553	690,153	5,006
16.00 01600	MEDICAL RECORDS & LIBRARY	0	58,609	12,423	71,032	353
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
23.00 02300	PARAMED PRGM-PASTORAL CARE	0	83,407	37	83,444	608
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	7,126,368	377,206	7,503,574	33,993
31.00 03100	INTENSIVE CARE UNIT	0	1,005,500	41,400	1,046,900	9,467
43.00 04300	NURSERY	0	0	0	0	2,893
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	676,363	2,026,206	745,695	3,448,264	19,474
52.00 05200	DELIVERY ROOM & LABOR ROOM	17,389	0	81,851	99,240	3,665
53.00 05300	ANESTHESIOLOGY	0	12,703	29,441	42,144	267
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	596,839	216,709	813,548	6,060
54.01 03630	ULTRASOUND	2,000	58,000	47,091	107,091	2,331
55.00 05500	RADIOLOGY-THERAPEUTIC	0	965,593	376,096	1,341,689	4,150
55.01 05501	CYBERKNIFE	0	0	83	83	876
56.00 05600	RADIO SOTOPE	0	133,066	11,383	144,449	936
57.00 05700	CT SCAN	0	86,069	44,935	131,004	1,687
58.00 05800	MRI	0	89,053	155,956	245,009	1,298
59.00 05900	CARDIAC CATHETERIZATION	0	400,866	181,835	582,701	2,774
60.00 06000	LABORATORY	13,920	942,945	185,516	1,142,381	11,297
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	35,928	202,614	11,395	249,937	2,817
65.01 03610	SLEEP LAB	300	0	43,174	43,474	684
66.00 06600	PHYSICAL THERAPY	0	51,712	12,598	64,310	5,251
67.00 06700	OCCUPATIONAL THERAPY	0	51,648	1,259	52,907	1,128
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	386
69.00 06900	ELECTROCARDIOLOGY	0	360,028	34,195	394,223	1,342
70.00 07000	ELECTROENCEPHALOGRAPHY	0	0	587	587	517
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	28,230	225	28,455	0
76.00 03020	CARDIAC REHABILITATION	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	0	26,508	26,508	695
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRIpsy	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	17,262	0	392,146	409,408	34,015
90.01 09001	OUTPATIENT CLINICS	23,485	0	44,997	68,482	3,783
90.02 09003	OUTPATIENT SERVICES	0	164,632	0	164,632	689
91.00 09100	EMERGENCY	0	1,059,297	36,388	1,095,685	9,353
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,590,460	20,758,138	12,476,828	34,825,426	195,769
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	211,981	6,761	218,742	563
190.01 19001	FOUNDATION	0	0	0	0	601
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	257,181	0	257,181	209
192.01 19201	SCHOOL NURSES	0	0	0	0	1,567
194.00 07950	OUTPATIENT PHARMACY	150	0	0	150	212
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118 through 201)	1,590,610	21,227,300	12,483,589	35,301,499	198,921

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 9:05 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	5,587,571			5.00		
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00		
7.00	00700	OPERATION OF PLANT	423,348	0	8,152,346	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	16,363	0	24,854	118,910	8.00	
9.00	00900	HOUSEKEEPING	99,315	0	22,965	899	187,786	9.00
10.00	01000	DIETARY	48,778	0	195,752	0	4,536	10.00
11.00	01100	CAFETERIA	25,738	0	274,546	0	6,361	11.00
13.00	01300	NURSING ADMINISTRATION	45,047	0	13,432	0	311	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	92,161	0	38,255	0	886	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,783	0	27,823	0	645	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	10,509	0	39,595	0	917	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	623,461	0	3,383,053	23,475	78,386	30.00
31.00	03100	INTENSIVE CARE UNIT	154,095	0	477,334	6,214	11,060	31.00
43.00	04300	NURSERY	49,460	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	410,878	0	961,887	11,208	22,287	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	62,971	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	9,865	0	6,031	0	140	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	102,443	0	283,334	4,443	6,565	54.00
54.01	03630	ULTRASOUND	35,954	0	27,534	66	638	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	84,153	0	458,390	172	10,621	55.00
55.01	05501	CYBERKNIFE	47,489	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	45,463	0	63,169	868	1,464	56.00
57.00	05700	CT SCAN	33,440	0	40,859	581	947	57.00
58.00	05800	MRI	26,023	0	42,275	1,521	980	58.00
59.00	05900	CARDIAC CATHETERIZATION	51,530	0	190,300	1,613	4,409	59.00
60.00	06000	LABORATORY	151,565	0	447,638	21	10,372	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	49,873	0	96,186	0	2,229	65.00
65.01	03610	SLEEP LAB	11,101	0	0	291	0	65.01
66.00	06600	PHYSICAL THERAPY	76,646	0	24,549	250	569	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,154	0	24,519	0	568	67.00
68.00	06800	SPEECH PATHOLOGY	5,564	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	26,507	0	170,914	0	3,960	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,445	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	503,813	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	633,245	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	588,397	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,025	0	13,401	138	311	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	10,563	0	0	34	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	612,689	0	0	1,066	0	90.00
90.01	09001	OUTPATIENT CLINICS	56,598	0	0	1,335	0	90.01
90.02	09003	OUTPATIENT SERVICES	13,438	0	78,155	542	1,811	90.02
91.00	09100	EMERGENCY	166,992	0	502,873	10,892	11,652	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,491,882	0	7,929,623	65,629	182,625	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,650	0	100,633	645	2,332	190.00
190.01	19001	FOUNDATION	8,888	0	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,668	0	122,090	52,636	2,829	192.00
192.01	19201	SCHOOL NURSES	22,500	0	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	13,983	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5,587,571	0	8,152,346	118,910	187,786	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 9:05 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	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	740,164					10.00
11.00	01100	CAFETERIA	0	886,998				11.00
13.00	01300	NURSING ADMINISTRATION	0	8,267	99,902			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	0	19,748	0	0	846,209	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	4,292	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	663,745	172,210	40,616	0	11	30.00
31.00	03100	INTENSIVE CARE UNIT	76,419	44,256	10,438	0	61	31.00
43.00	04300	NURSERY	0	12,466	2,940	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	101,081	23,840	0	424	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,120	0	0	8	52.00
53.00	05300	ANESTHESIOLOGY	0	2,192	495	0	5,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,712	0	0	0	54.00
54.01	03630	ULTRASOUND	0	8,911	0	0	17	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	16,553	3,904	0	0	55.00
55.01	05501	CYBERKNIFE	0	2,758	0	0	0	55.01
56.00	05600	RADIO SOTOP	0	3,335	0	0	33,230	56.00
57.00	05700	CT SCAN	0	6,526	0	0	2,417	57.00
58.00	05800	MRI	0	4,790	0	0	20	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,721	0	0	2	59.00
60.00	06000	LABORATORY	0	69,680	0	0	18,393	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	14,760	0	0	0	65.00
65.01	03610	SLEEP LAB	0	3,539	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	22,776	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,192	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,451	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,278	0	0	2	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,846	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	664,786	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,553	838	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	193,822	0	0	106,852	90.00
90.01	09001	OUTPATIENT CLINICS	0	15,994	3,772	0	327	90.01
90.02	09003	OUTPATIENT SERVICES	0	3,675	1,102	0	0	90.02
91.00	09100	EMERGENCY	0	51,220	11,957	0	1,605	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	740,164	867,724	99,902	0	833,999	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,164	0	0	0	190.00
190.01	19001	FOUNDATION	0	2,948	0	0	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	586	0	0	0	192.00
192.01	19201	SCHOOL NURSES	0	10,576	0	0	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	0	0	0	12,210	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	740,164	886,998	99,902	0	846,209	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0200

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

Worksheet B  
Part II  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM-PASTORAL CARE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		16.00	17.00	23.00	24.00	25.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,636				16.00
17.00	01700	SOCIAL SERVICE	0	0			17.00
23.00	02300	PARAMED ED PRGM-PASTORAL CARE	0	0	139,365		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	12,406	0		12,534,930	0 30.00
31.00	03100	INTENSIVE CARE UNIT	2,542	0		1,838,786	0 31.00
43.00	04300	NURSERY	1,294	0		69,053	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	12,975	0		5,012,318	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,348	0		191,352	0 52.00
53.00	05300	ANESTHESIOLOGY	5,590	0		72,568	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,430	0		1,256,535	0 54.00
54.01	03630	ULTRASOUND	1,910	0		184,452	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,988	0		1,922,620	0 55.00
55.01	05501	CYBERKNIFE	883	0		52,089	0 55.01
56.00	05600	RADIOISOTOPE	1,422	0		294,336	0 56.00
57.00	05700	CT SCAN	8,950	0		226,411	0 57.00
58.00	05800	MRI	3,683	0		325,599	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	4,066	0		846,116	0 59.00
60.00	06000	LABORATORY	14,248	0		1,865,595	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0 62.30
65.00	06500	RESPIRATORY THERAPY	2,101	0		417,903	0 65.00
65.01	03610	SLEEP LAB	512	0		59,601	0 65.01
66.00	06600	PHYSICAL THERAPY	1,688	0		196,039	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	445	0		100,913	0 67.00
68.00	06800	SPEECH PATHOLOGY	157	0		7,558	0 68.00
69.00	06900	ELECTROCARDIOLOGY	1,725	0		604,951	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	324	0		10,719	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,690	0		510,503	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,674	0		641,919	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,428	0		1,278,611	0 73.00
74.00	07400	RENAL DIALYSIS	231	0		57,561	0 74.00
76.00	03020	CARDIAC REHABILITATION	0	0		0	0 76.00
76.97	07697	CARDIAC REHABILITATION	424	0		42,615	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		0	0 76.98
76.99	07699	LITHOTRIPSY	0	0		0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	5,686	0		1,363,538	0 90.00
90.01	09001	OUTPATIENT CLINICS	761	0		151,052	0 90.01
90.02	09003	OUTPATIENT SERVICES	291	0		264,335	0 90.02
91.00	09100	EMERGENCY	11,764	0		1,873,993	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	146,636	0	0	34,274,571	0 118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		351,729	0 190.00
190.01	19001	FOUNDATION	0	0		12,437	0 190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		462,199	0 192.00
192.01	19201	SCHOOL NURSES	0	0		34,643	0 192.01
194.00	07950	OUTPATIENT PHARMACY	0	0		26,555	0 194.00
200.00		Cross Foot Adjustments			139,365	139,365	0 200.00
201.00		Negative Cost Centers	0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	146,636	0	139,365	35,301,499	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 9:05 am
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
23.00	02300 PARAMED ED PRGM-PASTORAL CARE		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	12,534,930	30.00
31.00	03100 INTENSIVE CARE UNIT	1,838,786	31.00
43.00	04300 NURSERY	69,053	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	5,012,318	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	191,352	52.00
53.00	05300 ANESTHESIOLOGY	72,568	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,256,535	54.00
54.01	03630 ULTRASOUND	184,452	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	1,922,620	55.00
55.01	05501 CYBERKNIFE	52,089	55.01
56.00	05600 RADIOISOTOPE	294,336	56.00
57.00	05700 CT SCAN	226,411	57.00
58.00	05800 MRI	325,599	58.00
59.00	05900 CARDIAC CATHETERIZATION	846,116	59.00
60.00	06000 LABORATORY	1,865,595	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500 RESPIRATORY THERAPY	417,903	65.00
65.01	03610 SLEEP LAB	59,601	65.01
66.00	06600 PHYSICAL THERAPY	196,039	66.00
67.00	06700 OCCUPATIONAL THERAPY	100,913	67.00
68.00	06800 SPEECH PATHOLOGY	7,558	68.00
69.00	06900 ELECTROCARDIOLOGY	604,951	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	10,719	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	510,503	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	641,919	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,278,611	73.00
74.00	07400 RENAL DIALYSIS	57,561	74.00
76.00	03020 CARDIAC REHABILITATION	0	76.00
76.97	07697 CARDIAC REHABILITATION	42,615	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699 LI THOTRIPSY	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	1,363,538	90.00
90.01	09001 OUTPATIENT CLINICS	151,052	90.01
90.02	09003 OUTPATIENT SERVICES	264,335	90.02
91.00	09100 EMERGENCY	1,873,993	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE		113.00
118.00	11800 SUBTOTALS (SUM OF LINES 1 through 117)	34,274,571	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	351,729	190.00
190.01	19001 FOUNDATION	12,437	190.01
192.00	19200 PHYSICIANS' PRIVATE OFFICES	462,199	192.00
192.01	19201 SCHOOL NURSES	34,643	192.01
194.00	07950 OUTPATIENT PHARMACY	26,555	194.00
200.00	Cross Foot Adjustments	139,365	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	35,301,499	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	661,709				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		27,527,756			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,933	18,949	130,434,656		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	86,175	5,692,194	6,552,242	-85,086,794	333,501,578
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	34,280	14,610,060	2,480,078	0	25,268,491
8.00 00800	LAUNDRY & LINEN SERVICE	1,632	52,248	881,839	0	976,683
9.00 00900	HOUSEKEEPING	1,508	23,230	3,734,844	0	5,927,837
10.00 01000	DIETARY	12,854	158,907	1,282,652	0	2,911,441
11.00 01100	CAFETERIA	18,028	0	1,327,196	0	1,536,235
13.00 01300	NURSING ADMINISTRATION	882	3,026	2,084,811	0	2,688,733
14.00 01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
15.00 01500	PHARMACY	2,512	93,835	3,282,863	0	5,500,811
16.00 01600	MEDICAL RECORDS & LIBRARY	1,827	27,395	231,387	0	2,792,372
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
23.00 02300	PARAMED PRGM-PASTORAL CARE	2,600	81	398,733	0	627,232
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	222,147	831,783	22,290,487	0	37,212,686
31.00 03100	INTENSIVE CARE UNIT	31,344	91,292	6,207,914	0	9,197,493
43.00 04300	NURSERY	0	0	1,896,779	0	2,952,112
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	63,162	1,644,344	12,769,733	0	24,524,195
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	180,492	2,403,196	0	3,758,594
53.00 05300	ANESTHESIOLOGY	396	64,920	175,226	0	588,799
54.00 05400	RADIOLOGY-DIAGNOSTIC	18,605	477,869	3,973,769	0	6,114,516
54.01 03630	ULTRASOUND	1,808	103,842	1,528,217	0	2,146,005
55.00 05500	RADIOLOGY-THERAPEUTIC	30,100	829,335	2,721,170	0	5,022,855
55.01 05501	CYBERKNIFE	0	182	574,691	0	2,834,471
56.00 05600	RADIOISOTOPE	4,148	25,100	613,647	0	2,713,555
57.00 05700	CT SCAN	2,683	99,087	1,106,046	0	1,995,931
58.00 05800	MRI	2,776	343,901	851,283	0	1,553,254
59.00 05900	CARDIAC CATHETERIZATION	12,496	400,967	1,819,199	0	3,075,668
60.00 06000	LABORATORY	29,394	409,084	7,407,979	0	9,046,491
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	6,316	25,127	1,847,495	0	2,976,783
65.01 03610	SLEEP LAB	0	95,204	448,282	0	662,615
66.00 06600	PHYSICAL THERAPY	1,612	27,780	3,443,582	0	4,574,782
67.00 06700	OCCUPATIONAL THERAPY	1,610	2,776	739,699	0	1,023,880
68.00 06800	SPEECH PATHOLOGY	0	0	253,255	0	332,080
69.00 06900	ELECTROCARDIOLOGY	11,223	75,403	879,680	0	1,582,157
70.00 07000	ELECTROENCEPHALOGRAPHY	0	1,294	339,244	0	444,343
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	30,071,185
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	37,791,491
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	35,119,811
74.00 07400	RENAL DIALYSIS	880	497	0	0	896,808
76.00 03020	CARDIAC REHABILITATION	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	58,453	455,705	0	630,496
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LITHOTRI PSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	864,727	22,298,400	0	36,569,724
90.01 09001	OUTPATIENT CLINICS	0	99,224	2,480,922	0	3,378,166
90.02 09003	OUTPATIENT SERVICES	5,132	0	452,030	0	802,059
91.00 09100	EMERGENCY	33,021	80,240	6,133,276	0	9,967,314
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	647,084	27,512,848	128,367,551	-85,086,794	327,790,154
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,608	14,908	368,955	0	1,411,579
190.01 19001	FOUNDATION	0	0	394,332	0	530,530
192.00 19200	PHYSICIANS' PRIVATE OFFICES	8,017	0	137,101	0	1,591,739
192.01 19201	SCHOOL NURSES	0	0	1,027,576	0	1,342,942
194.00 07950	OUTPATIENT PHARMACY	0	0	139,141	0	834,634
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	21,227,300	12,483,589	40,030,746		85,086,794

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
203.00	Unit cost multiplier (Wkst. B, Part I)	32.079509	0.453491	0.306903	0.255132	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			198,921	5,587,571	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001525	0.016754	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: 14-0200

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

Worksheet B-1

Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	0					6.00
7.00	00700		535,321				7.00
8.00	00800		1,632	3,863,915			8.00
9.00	00900	0	1,508	29,212	532,181		9.00
10.00	01000	0	12,854	0	12,854	189,567	10.00
11.00	01100	0	18,028	0	18,028	0	11.00
13.00	01300	0	882	0	882	0	13.00
14.00	01400	0	0	0	0	0	14.00
15.00	01500	0	2,512	0	2,512	0	15.00
16.00	01600	0	1,827	0	1,827	0	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	0	2,600	0	2,600	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	222,147	762,813	222,147	169,995	30.00
31.00	03100	0	31,344	201,922	31,344	19,572	31.00
43.00	04300	0	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	63,162	364,206	63,162	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	396	0	396	0	53.00
54.00	05400	0	18,605	144,366	18,605	0	54.00
54.01	03630	0	1,808	2,150	1,808	0	54.01
55.00	05500	0	30,100	5,577	30,100	0	55.00
55.01	05501	0	0	0	0	0	55.01
56.00	05600	0	4,148	28,205	4,148	0	56.00
57.00	05700	0	2,683	18,869	2,683	0	57.00
58.00	05800	0	2,776	49,429	2,776	0	58.00
59.00	05900	0	12,496	52,429	12,496	0	59.00
60.00	06000	0	29,394	684	29,394	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	6,316	0	6,316	0	65.00
65.01	03610	0	0	9,454	0	0	65.01
66.00	06600	0	1,612	8,123	1,612	0	66.00
67.00	06700	0	1,610	0	1,610	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	11,223	0	11,223	0	69.00
70.00	07000	0	0	0	0	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	880	4,477	880	0	74.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	0	0	1,119	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	34,652	0	0	90.00
90.01	09001	0	0	43,390	0	0	90.01
90.02	09003	0	5,132	17,623	5,132	0	90.02
91.00	09100	0	33,021	353,946	33,021	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	0	0	0	0	0	113.00
118.00		0	520,696	2,132,646	517,556	189,567	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	0	6,608	20,972	6,608	0	190.00
190.01	19001	0	0	0	0	0	190.01
192.00	19200	0	8,017	1,710,297	8,017	0	192.00
192.01	19201	0	0	0	0	0	192.01
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		0	31,715,292	1,322,554	7,539,559	4,597,889	202.00
203.00		0.000000	59,245,372	0,342,283	14,167,283	24,254,691	203.00
204.00		0	8,152,346	118,910	187,786	740,164	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	15.228893	0.030774	0.352861	3.904498	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: 14-0200

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

Worksheet B-1  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION  (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,447,056					11.00
13.00	01300	32,127	1,646,149				13.00
14.00	01400	0	0	0			14.00
15.00	01500	76,743	0	0	44,704,270		15.00
16.00	01600	0	0	0	0	2,502,416,828	16.00
17.00	01700	0	0	0	0	0	17.00
23.00	02300	16,680	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	669,246	669,246	0	606	210,273,553	30.00
31.00	03100	171,987	171,987	0	3,217	43,082,168	31.00
43.00	04300	48,447	48,447	0	0	21,933,528	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	392,824	392,824	0	22,404	219,921,813	50.00
52.00	05200	93,736	0	0	420	22,853,274	52.00
53.00	05300	8,519	8,159	0	308,734	94,747,668	53.00
54.00	05400	134,898	0	0	0	92,036,232	54.00
54.01	03630	34,630	0	0	897	32,374,364	54.01
55.00	05500	64,328	64,328	0	0	50,643,022	55.00
55.01	05501	10,719	0	0	0	14,968,889	55.01
56.00	05600	12,959	0	0	1,755,518	24,098,103	56.00
57.00	05700	25,363	0	0	127,680	151,694,968	57.00
58.00	05800	18,615	0	0	1,071	62,421,338	58.00
59.00	05900	33,892	0	0	94	68,920,843	59.00
60.00	06000	270,791	0	0	971,695	241,495,925	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	57,360	0	0	0	35,611,826	65.00
65.01	03610	13,753	0	0	0	8,681,006	65.01
66.00	06600	88,513	0	0	0	28,602,387	66.00
67.00	06700	16,291	0	0	4	7,538,096	67.00
68.00	06800	5,638	0	0	0	2,657,489	68.00
69.00	06900	24,396	0	0	113	29,234,437	69.00
70.00	07000	7,173	0	0	0	5,490,294	70.00
71.00	07100	0	0	0	0	113,393,707	71.00
72.00	07200	0	0	0	0	147,011,635	72.00
73.00	07300	0	0	0	35,119,811	448,056,893	73.00
74.00	07400	0	0	0	5	3,912,990	74.00
76.00	03020	0	0	0	0	0	76.00
76.97	07697	13,809	13,809	0	4	7,181,146	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	753,223	0	0	5,644,892	96,366,831	90.00
90.01	09001	62,157	62,157	0	17,263	12,899,879	90.01
90.02	09003	14,282	18,165	0	0	4,929,141	90.02
91.00	09100	199,052	197,027	0	84,792	199,383,383	91.00
92.00	09200						92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		3,372,151	1,646,149	0	44,059,220	2,502,416,828	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	20,068	0	0	0	0	190.00
190.01	19001	11,458	0	0	0	0	190.01
192.00	19200	2,279	0	0	0	0	192.00
192.01	19201	41,100	0	0	0	0	192.01
194.00	07950	0	0	0	645,050	0	194.00
200.00							200.00
201.00							201.00
202.00		3,251,662	3,469,771	0	7,161,049	3,638,920	202.00
203.00		0.943316	2.107811	0.000000	0.160187	0.001454	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1

Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
		11.00	13.00	14.00	15.00	16.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	886,998	99,902	0	846,209	146,636	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.257320	0.060688	0.000000	0.018929	0.000059	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: 14-0200

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

Worksheet B-1  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMED PRGM-PASTORAL CARE (ASSIGNED TIME)	
		17.00	23.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	0	17.00
23.00	02300	PARAMED PRGM-PASTORAL CARE	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
43.00	04300	NURSERY	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	03630	ULTRASOUND	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
55.01	05501	CYBERKNIFE	0	55.01
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
65.01	03610	SLEEP LAB	0	65.01
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LI THOTRI PSY	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0	90.00
90.01	09001	OUTPATIENT CLINICS	0	90.01
90.02	09003	OUTPATIENT SERVICES	33	90.02
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	50	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
190.01	19001	FOUNDATION	0	190.01
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	SCHOOL NURSES	0	192.01
194.00	07950	OUTPATIENT PHARMACY	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
			3,135.227129	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0200

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

Worksheet B-1  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	PARAMED PRGM-PASTORAL CARE (ASSIGNED TIME)	
		17.00	23.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	139,365	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	439.637224	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	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS		70,324,185	0	70,324,185	30.00
31.00	03100	INTENSIVE CARE UNIT		15,133,612	0	15,133,612	31.00
43.00	04300	NURSERY		3,884,999	0	3,884,999	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM		37,064,565	0	37,064,565	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		4,839,251	0	4,839,251	52.00
53.00	05300	ANESTHESIOLOGY		980,543	0	980,543	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		9,350,853	0	9,350,853	54.00
54.01	03630	ULTRASOUND		2,906,869	0	2,906,869	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		8,785,884	0	8,785,884	55.00
55.01	05501	CYBERKNIFE		3,589,511	0	3,589,511	55.01
56.00	05600	RADIOISOTOPE		4,048,514	0	4,048,514	56.00
57.00	05700	CT SCAN		2,973,524	0	2,973,524	57.00
58.00	05800	MRI		2,278,744	0	2,278,744	58.00
59.00	05900	CARDIAC CATHETERIZATION		4,927,876	0	4,927,876	59.00
60.00	06000	LABORATORY		14,274,894	0	14,274,894	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	4,305,820	0	4,305,820	65.00
65.01	03610	SLEEP LAB	0	860,500	0	860,500	65.01
66.00	06600	PHYSICAL THERAPY	0	5,988,161	0	5,988,161	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,429,628	0	1,429,628	67.00
68.00	06800	SPEECH PATHOLOGY	0	425,986	0	425,986	68.00
69.00	06900	ELECTROCARDIOLOGY		2,875,264	0	2,875,264	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		572,458	0	572,458	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		37,908,181	0	37,908,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		47,646,932	0	47,646,932	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		50,357,624	0	50,357,624	73.00
74.00	07400	RENAL DIALYSIS		1,197,437	0	1,197,437	74.00
76.00	03020	CARDIAC REHABILITATION		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		844,314	0	844,314	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC		47,666,575	294,363	47,960,938	90.00
90.01	09001	OUTPATIENT CLINICS		4,569,528	0	4,569,528	90.01
90.02	09003	OUTPATIENT SERVICES		1,448,402	0	1,448,402	90.02
91.00	09100	EMERGENCY		16,118,916	0	16,118,916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		6,808,347	0	6,808,347	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	0	416,387,897	294,363	416,682,260	200.00
201.00		Less Observation Beds		6,808,347		6,808,347	201.00
202.00		Total (see instructions)	0	409,579,550	294,363	409,873,913	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	196,540,471		196,540,471		30.00
31.00	03100	INTENSIVE CARE UNIT	43,082,168		43,082,168		31.00
43.00	04300	NURSERY	21,933,528		21,933,528		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	121,389,348	98,532,465	219,921,813	0.168535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,615,485	4,237,789	22,853,274	0.211753	52.00
53.00	05300	ANESTHESIOLOGY	51,192,001	43,555,667	94,747,668	0.010349	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,826,379	62,209,853	92,036,232	0.101600	54.00
54.01	03630	ULTRASOUND	5,475,004	26,899,360	32,374,364	0.089789	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	249,720	50,393,302	50,643,022	0.173487	55.00
55.01	05501	CYBERKNIFE	25,195	14,943,694	14,968,889	0.239798	55.01
56.00	05600	RADIOISOTOPE	5,161,860	18,936,243	24,098,103	0.168001	56.00
57.00	05700	CT SCAN	39,364,725	112,330,243	151,694,968	0.019602	57.00
58.00	05800	MRI	11,871,229	50,550,109	62,421,338	0.036506	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,576,330	41,344,513	68,920,843	0.071501	59.00
60.00	06000	LABORATORY	66,576,766	174,919,159	241,495,925	0.059110	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	32,201,210	3,410,616	35,611,826	0.120910	65.00
65.01	03610	SLEEP LAB	5,721	8,675,285	8,681,006	0.099124	65.01
66.00	06600	PHYSICAL THERAPY	11,468,287	17,134,100	28,602,387	0.209359	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,792,407	1,745,689	7,538,096	0.189654	67.00
68.00	06800	SPEECH PATHOLOGY	2,560,712	96,777	2,657,489	0.160296	68.00
69.00	06900	ELECTROCARDIOLOGY	12,253,758	16,980,679	29,234,437	0.098352	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,613,778	876,516	5,490,294	0.104267	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,295,412	45,098,295	113,393,707	0.334306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107,293,981	39,717,654	147,011,635	0.324103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	225,395,813	222,661,080	448,056,893	0.112391	73.00
74.00	07400	RENAL DIALYSIS	3,755,278	157,712	3,912,990	0.306016	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	277,836	6,903,310	7,181,146	0.117574	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	356,445	96,010,386	96,366,831	0.494637	90.00
90.01	09001	OUTPATIENT CLINICS	754,764	12,145,115	12,899,879	0.354230	90.01
90.02	09003	OUTPATIENT SERVICES	0	4,929,141	4,929,141	0.293845	90.02
91.00	09100	EMERGENCY	53,295,260	146,088,123	199,383,383	0.080844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,284,528	12,448,554	13,733,082	0.495762	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,168,485,399	1,333,931,429	2,502,416,828		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,168,485,399	1,333,931,429	2,502,416,828		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 9:05 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	0.168535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211753	52.00
53.00	05300	ANESTHESIOLOGY	0.010349	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.101600	54.00
54.01	03630	ULTRASOUND	0.089789	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.173487	55.00
55.01	05501	CYBERKNIFE	0.239798	55.01
56.00	05600	RADIOISOTOPE	0.168001	56.00
57.00	05700	CT SCAN	0.019602	57.00
58.00	05800	MRI	0.036506	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071501	59.00
60.00	06000	LABORATORY	0.059110	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.120910	65.00
65.01	03610	SLEEP LAB	0.099124	65.01
66.00	06600	PHYSICAL THERAPY	0.209359	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.189654	67.00
68.00	06800	SPEECH PATHOLOGY	0.160296	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098352	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.104267	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.334306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.324103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112391	73.00
74.00	07400	RENAL DIALYSIS	0.306016	74.00
76.00	03020	CARDIAC REHABILITATION	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0.117574	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	0.497691	90.00
90.01	09001	OUTPATIENT CLINICS	0.354230	90.01
90.02	09003	OUTPATIENT SERVICES	0.293845	90.02
91.00	09100	EMERGENCY	0.080844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.495762	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS		70,324,185	0	70,324,185	30.00
31.00	03100 INTENSIVE CARE UNIT		15,133,612	0	15,133,612	31.00
43.00	04300 NURSERY		3,884,999	0	3,884,999	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM		37,064,565	0	37,064,565	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		4,839,251	0	4,839,251	52.00
53.00	05300 ANESTHESIOLOGY		980,543	0	980,543	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		9,350,853	0	9,350,853	54.00
54.01	03630 ULTRASOUND		2,906,869	0	2,906,869	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC		8,785,884	0	8,785,884	55.00
55.01	05501 CYBERKNIFE		3,589,511	0	3,589,511	55.01
56.00	05600 RADIOISOTOPE		4,048,514	0	4,048,514	56.00
57.00	05700 CT SCAN		2,973,524	0	2,973,524	57.00
58.00	05800 MRI		2,278,744	0	2,278,744	58.00
59.00	05900 CARDIAC CATHETERIZATION		4,927,876	0	4,927,876	59.00
60.00	06000 LABORATORY		14,274,894	0	14,274,894	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	4,305,820	0	4,305,820	65.00
65.01	03610 SLEEP LAB	0	860,500	0	860,500	65.01
66.00	06600 PHYSICAL THERAPY	0	5,988,161	0	5,988,161	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,429,628	0	1,429,628	67.00
68.00	06800 SPEECH PATHOLOGY	0	425,986	0	425,986	68.00
69.00	06900 ELECTROCARDIOLOGY		2,875,264	0	2,875,264	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		572,458	0	572,458	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		37,908,181	0	37,908,181	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		47,646,932	0	47,646,932	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		50,357,624	0	50,357,624	73.00
74.00	07400 RENAL DIALYSIS		1,197,437	0	1,197,437	74.00
76.00	03020 CARDIAC REHABILITATION		0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION		844,314	0	844,314	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY		0	0	0	76.98
76.99	07699 LI THOTRI PSY		0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000 CLINIC		47,666,575	294,363	47,960,938	90.00
90.01	09001 OUTPATIENT CLINICS		4,569,528	0	4,569,528	90.01
90.02	09003 OUTPATIENT SERVICES		1,448,402	0	1,448,402	90.02
91.00	09100 EMERGENCY		16,118,916	0	16,118,916	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		6,808,347	0	6,808,347	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	416,387,897	294,363	416,682,260	200.00
201.00	Less Observation Beds		6,808,347		6,808,347	201.00
202.00	Total (see instructions)	0	409,579,550	294,363	409,873,913	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0200

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

Worksheet C  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	196,540,471		196,540,471		30.00
31.00	03100	INTENSIVE CARE UNIT	43,082,168		43,082,168		31.00
43.00	04300	NURSERY	21,933,528		21,933,528		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	121,389,348	98,532,465	219,921,813	0.168535	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,615,485	4,237,789	22,853,274	0.211753	52.00
53.00	05300	ANESTHESIOLOGY	51,192,001	43,555,667	94,747,668	0.010349	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,826,379	62,209,853	92,036,232	0.101600	54.00
54.01	03630	ULTRASOUND	5,475,004	26,899,360	32,374,364	0.089789	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	249,720	50,393,302	50,643,022	0.173487	55.00
55.01	05501	CYBERKNIFE	25,195	14,943,694	14,968,889	0.239798	55.01
56.00	05600	RADIOISOTOPE	5,161,860	18,936,243	24,098,103	0.168001	56.00
57.00	05700	CT SCAN	39,364,725	112,330,243	151,694,968	0.019602	57.00
58.00	05800	MRI	11,871,229	50,550,109	62,421,338	0.036506	58.00
59.00	05900	CARDIAC CATHETERIZATION	27,576,330	41,344,513	68,920,843	0.071501	59.00
60.00	06000	LABORATORY	66,576,766	174,919,159	241,495,925	0.059110	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	32,201,210	3,410,616	35,611,826	0.120910	65.00
65.01	03610	SLEEP LAB	5,721	8,675,285	8,681,006	0.099124	65.01
66.00	06600	PHYSICAL THERAPY	11,468,287	17,134,100	28,602,387	0.209359	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,792,407	1,745,689	7,538,096	0.189654	67.00
68.00	06800	SPEECH PATHOLOGY	2,560,712	96,777	2,657,489	0.160296	68.00
69.00	06900	ELECTROCARDIOLOGY	12,253,758	16,980,679	29,234,437	0.098352	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,613,778	876,516	5,490,294	0.104267	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,295,412	45,098,295	113,393,707	0.334306	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107,293,981	39,717,654	147,011,635	0.324103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	225,395,813	222,661,080	448,056,893	0.112391	73.00
74.00	07400	RENAL DIALYSIS	3,755,278	157,712	3,912,990	0.306016	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	277,836	6,903,310	7,181,146	0.117574	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	356,445	96,010,386	96,366,831	0.494637	90.00
90.01	09001	OUTPATIENT CLINICS	754,764	12,145,115	12,899,879	0.354230	90.01
90.02	09003	OUTPATIENT SERVICES	0	4,929,141	4,929,141	0.293845	90.02
91.00	09100	EMERGENCY	53,295,260	146,088,123	199,383,383	0.080844	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,284,528	12,448,554	13,733,082	0.495762	92.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	1,168,485,399	1,333,931,429	2,502,416,828		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	1,168,485,399	1,333,931,429	2,502,416,828		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 9:05 am
		Title XIX	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000		50.00
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	03630 ULTRASOUND	0.000000		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
55.01	05501 CYBERKNIFE	0.000000		55.01
56.00	05600 RADIOISOTOPE	0.000000		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MRI	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
65.01	03610 SLEEP LAB	0.000000		65.01
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
76.00	03020 CARDIAC REHABILITATION	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0.000000		76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 OUTPATIENT CLINICS	0.000000		90.01
90.02	09003 OUTPATIENT SERVICES	0.000000		90.02
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part I Date/Time Prepared: 11/28/2018 9:05 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00		
30.00	ADULTS & PEDIATRICS	12,534,930	0	12,534,930	62,739	199.79	30.00	
31.00	INTENSIVE CARE UNIT	1,838,786		1,838,786	9,786	187.90	31.00	
43.00	NURSERY	69,053		69,053	6,476	10.66	43.00	
200.00	Total (lines 30 through 199)	14,442,769		14,442,769	79,001		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00					
30.00	ADULTS & PEDIATRICS	26,658	5,326,002					30.00
31.00	INTENSIVE CARE UNIT	2,028	381,061					31.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	28,686	5,707,063					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part II Date/Time Prepared: 11/28/2018 9:05 am
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	5,012,318	219,921,813	0.022791	44,819,180	1,021,474	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	191,352	22,853,274	0.008373	26,692	223	52.00
53.00	05300 ANESTHESIOLOGY	72,568	94,747,668	0.000766	18,381,774	14,080	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,256,535	92,036,232	0.013653	13,944,441	190,383	54.00
54.01	03630 ULTRASOUND	184,452	32,374,364	0.005697	2,388,252	13,606	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	1,922,620	50,643,022	0.037964	113,685	4,316	55.00
55.01	05501 CYBERKNIFE	52,089	14,968,889	0.003480	18,733	65	55.01
56.00	05600 RADIOISOTOPE	294,336	24,098,103	0.012214	2,351,422	28,720	56.00
57.00	05700 CT SCAN	226,411	151,694,968	0.001493	17,330,975	25,875	57.00
58.00	05800 MRI	325,599	62,421,338	0.005216	4,528,212	23,619	58.00
59.00	05900 CARDIAC CATHETERIZATION	846,116	68,920,843	0.012277	11,929,095	146,453	59.00
60.00	06000 LABORATORY	1,865,595	241,495,925	0.007725	27,535,335	212,710	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	417,903	35,611,826	0.011735	17,352,488	203,631	65.00
65.01	03610 SLEEP LAB	59,601	8,681,006	0.006866	5,635	39	65.01
66.00	06600 PHYSICAL THERAPY	196,039	28,602,387	0.006854	6,012,327	41,208	66.00
67.00	06700 OCCUPATIONAL THERAPY	100,913	7,538,096	0.013387	3,028,934	40,548	67.00
68.00	06800 SPEECH PATHOLOGY	7,558	2,657,489	0.002844	1,481,692	4,214	68.00
69.00	06900 ELECTROCARDIOLOGY	604,951	29,234,437	0.020693	5,932,496	122,761	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	10,719	5,490,294	0.001952	2,052,458	4,006	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	510,503	113,393,707	0.004502	27,185,195	122,388	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	641,919	147,011,635	0.004366	40,367,098	176,243	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,278,611	448,056,893	0.002854	92,383,585	263,663	73.00
74.00	07400 RENAL DIALYSIS	57,561	3,912,990	0.014710	2,138,563	31,458	74.00
76.00	03020 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	42,615	7,181,146	0.005934	110,551	656	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRIpsy	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	1,363,538	96,366,831	0.014149	120,288	1,702	90.00
90.01	09001 OUTPATIENT CLINICS	151,052	12,899,879	0.011710	379,164	4,440	90.01
90.02	09003 OUTPATIENT SERVICES	264,335	4,929,141	0.053627	0	0	90.02
91.00	09100 EMERGENCY	1,873,993	199,383,383	0.009399	24,659,094	231,771	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,213,554	13,733,082	0.088367	666,570	58,903	92.00
200.00	Total (lines 50 through 199)	21,045,356	2,240,860,661		367,243,934	2,989,155	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/28/2018 9:05 am		
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	576,883	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	156,761	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	733,644	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	576,883	62,739	9.19	26,658	30.00	
31.00	03100	INTENSIVE CARE UNIT		156,761	9,786	16.02	2,028	31.00	
43.00	04300	NURSERY		0	6,476	0.00	0	43.00	
200.00		Total (lines 30 through 199)		733,644	79,001		28,686	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	244,987						30.00
31.00	03100	INTENSIVE CARE UNIT	32,489						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	277,476						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 9:05 am
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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			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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	03630	ULTRASOUND	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
55.01	05501	CYBERKNIFE	0	0	0	0	0	55.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03610	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT CLINICS	0	0	0	0	103,462	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	156,761	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	55,849	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	316,072	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 9:05 am
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Cost Center Description	Title XVIII			Hospital	PPS			
	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)			
	4.00	5.00	6.00	7.00	8.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	219,921,813	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	22,853,274	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	94,747,668	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	92,036,232	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	32,374,364	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	50,643,022	0.000000	55.00
55.01	05501	CYBERKNIFE	0	0	0	14,968,889	0.000000	55.01
56.00	05600	RADIOISOTOPE	0	0	0	24,098,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	151,694,968	0.000000	57.00
58.00	05800	MRI	0	0	0	62,421,338	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	68,920,843	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	241,495,925	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	35,611,826	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	8,681,006	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	28,602,387	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,538,096	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,657,489	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,234,437	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,490,294	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	113,393,707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	147,011,635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	448,056,893	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,912,990	0.000000	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	7,181,146	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	96,366,831	0.000000	90.00
90.01	09001	OUTPATIENT CLINICS	0	103,462	103,462	12,899,879	0.008020	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	4,929,141	0.000000	90.02
91.00	09100	EMERGENCY	0	156,761	156,761	199,383,383	0.000786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	55,849	55,849	13,733,082	0.004067	92.00
200.00		Total (lines 50 through 199)	0	316,072	316,072	2,240,860,661		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 9:05 am
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Cost Center Description		Title XVIII			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	44,819,180	0	20,828,438	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	26,692	0	1,016	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	18,381,774	0	8,571,052	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	13,944,441	0	14,498,929	0	54.00
54.01	03630 ULTRASOUND	0.000000	2,388,252	0	4,762,288	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	113,685	0	16,883,471	0	55.00
55.01	05501 CYBERKNIFE	0.000000	18,733	0	7,186,705	0	55.01
56.00	05600 RADIOISOTOPE	0.000000	2,351,422	0	6,161,285	0	56.00
57.00	05700 CT SCAN	0.000000	17,330,975	0	30,719,514	0	57.00
58.00	05800 MRI	0.000000	4,528,212	0	11,740,360	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	11,929,095	0	17,108,495	0	59.00
60.00	06000 LABORATORY	0.000000	27,535,335	0	19,198,197	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	17,352,488	0	821,699	0	65.00
65.01	03610 SLEEP LAB	0.000000	5,635	0	1,831,806	0	65.01
66.00	06600 PHYSICAL THERAPY	0.000000	6,012,327	0	485,711	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	3,028,934	0	68,412	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	1,481,692	0	2,474	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	5,932,496	0	4,649,576	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	2,052,458	0	222,342	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	27,185,195	0	12,716,307	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	40,367,098	0	14,949,961	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	92,383,585	0	72,343,995	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	2,138,563	0	105,923	0	74.00
76.00	03020 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	110,551	0	2,860,873	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
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	120,288	0	18,978,823	0	90.00
90.01	09001 OUTPATIENT CLINICS	0.008020	379,164	3,041	3,142,988	25,207	90.01
90.02	09003 OUTPATIENT SERVICES	0.000000	0	0	1,766,188	0	90.02
91.00	09100 EMERGENCY	0.000786	24,659,094	19,382	27,106,573	21,306	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.004067	666,570	2,711	3,691,154	15,012	92.00
200.00	Total (lines 50 through 199)		367,243,934	25,134	323,404,555	61,525	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 9:05 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.168535	20,828,438	1	616	3,510,321	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.211753	1,016	0	0	215	52.00
53.00	05300	ANESTHESIOLOGY	0.010349	8,571,052	0	0	88,702	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.101600	14,498,929	0	58	1,473,091	54.00
54.01	03630	ULTRASOUND	0.089789	4,762,288	0	0	427,601	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.173487	16,883,471	0	0	2,929,063	55.00
55.01	05501	CYBERKNIFE	0.239798	7,186,705	0	0	1,723,357	55.01
56.00	05600	RADIOLOGY-SOTOP	0.168001	6,161,285	0	0	1,035,102	56.00
57.00	05700	CT SCAN	0.019602	30,719,514	3	1,349	602,164	57.00
58.00	05800	MRI	0.036506	11,740,360	8	3,318	428,594	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.071501	17,108,495	2	667	1,223,275	59.00
60.00	06000	LABORATORY	0.059110	19,198,197	4,525	0	1,134,805	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.120910	821,699	0	0	99,352	65.00
65.01	03610	SLEEP LAB	0.099124	1,831,806	0	0	181,576	65.01
66.00	06600	PHYSICAL THERAPY	0.209359	485,711	0	3	101,688	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.189654	68,412	0	0	12,975	67.00
68.00	06800	SPEECH PATHOLOGY	0.160296	2,474	0	0	397	68.00
69.00	06900	ELECTROCARDIOLOGY	0.098352	4,649,576	1	548	457,295	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.104267	222,342	0	0	23,183	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.334306	12,716,307	0	0	4,251,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.324103	14,949,961	434	0	4,845,327	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.112391	72,343,995	1,094	475,140	8,130,814	73.00
74.00	07400	RENAL DIALYSIS	0.306016	105,923	0	0	32,414	74.00
76.00	03020	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.117574	2,860,873	0	0	336,364	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0.494637	18,978,823	49	19,907	9,387,628	90.00
90.01	09001	OUTPATIENT CLINICS	0.354230	3,142,988	1	369	1,113,341	90.01
90.02	09003	OUTPATIENT SERVICES	0.293845	1,766,188	0	14	518,986	90.02
91.00	09100	EMERGENCY	0.080844	27,106,573	0	111	2,191,404	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.495762	3,691,154	0	0	1,829,934	92.00
200.00		Subtotal (see instructions)		323,404,555	6,118	502,100	48,090,106	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		323,404,555	6,118	502,100	48,090,106	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 9:05 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	104	50.00
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	6	54.00
54.01	03630 ULTRASOUND	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
55.01	05501 CYBERKNIFE	0	0	55.01
56.00	05600 RADIOISOTOPE	0	0	56.00
57.00	05700 CT SCAN	0	26	57.00
58.00	05800 MRI	0	121	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	48	59.00
60.00	06000 LABORATORY	267	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
65.01	03610 SLEEP LAB	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	1	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	54	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	141	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	123	53,401	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03020 CARDIAC REHABILITATION	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000 CLINIC	24	9,847	90.00
90.01	09001 OUTPATIENT CLINICS	0	131	90.01
90.02	09003 OUTPATIENT SERVICES	0	4	90.02
91.00	09100 EMERGENCY	0	9	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00	Subtotal (see instructions)	555	63,752	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 - line 201)	555	63,752	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet D Part III Date/Time Prepared: 11/28/2018 9:05 am	
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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	576,883	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	156,761	0	31.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	733,644	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of col. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	576,883	62,739	9.19	2,178	30.00	
31.00	03100	INTENSIVE CARE UNIT		156,761	9,786	16.02	124	31.00	
43.00	04300	NURSERY		0	6,476	0.00	1,182	43.00	
200.00		Total (lines 30 through 199)		733,644	79,001		3,484	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	20,016						30.00
31.00	03100	INTENSIVE CARE UNIT	1,986						31.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	22,002						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 9:05 am
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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		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
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 03630 ULTRASOUND	0	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
55.01 05501 CYBERKNIFE	0	0	0	0	0	0	55.01
56.00 05600 RADIOISOTOPE	0	0	0	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 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
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01 03610 SLEEP LAB	0	0	0	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00 03020 CARDIAC REHABILITATION	0	0	0	0	0	0	76.00
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00 09000 CLINIC	0	0	0	0	0	0	90.00
90.01 09001 OUTPATIENT CLINICS	0	0	0	0	0	103,462	90.01
90.02 09003 OUTPATIENT SERVICES	0	0	0	0	0	0	90.02
91.00 09100 EMERGENCY	0	0	0	0	0	156,761	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	260,223	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 9:05 am
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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		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	219,921,813	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	22,853,274	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	94,747,668	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	92,036,232	0.000000	54.00
54.01	03630	ULTRASOUND	0	0	0	32,374,364	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	50,643,022	0.000000	55.00
55.01	05501	CYBERKNIFE	0	0	0	14,968,889	0.000000	55.01
56.00	05600	RADIOISOTOPE	0	0	0	24,098,103	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	151,694,968	0.000000	57.00
58.00	05800	MRI	0	0	0	62,421,338	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	68,920,843	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	241,495,925	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	35,611,826	0.000000	65.00
65.01	03610	SLEEP LAB	0	0	0	8,681,006	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	28,602,387	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	7,538,096	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,657,489	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	29,234,437	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,490,294	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	113,393,707	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	147,011,635	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	448,056,893	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,912,990	0.000000	74.00
76.00	03020	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	7,181,146	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
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	96,366,831	0.000000	90.00
90.01	09001	OUTPATIENT CLINICS	0	103,462	103,462	12,899,879	0.008020	90.01
90.02	09003	OUTPATIENT SERVICES	0	0	0	4,929,141	0.000000	90.02
91.00	09100	EMERGENCY	0	156,761	156,761	199,383,383	0.000786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,733,082	0.000000	92.00
200.00		Total (lines 50 through 199)	0	260,223	260,223	2,240,860,661		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0200

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

Worksheet D  
Part IV  
Date/Time Prepared:  
11/28/2018 9:05 am

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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
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	03630 ULTRASOUND	0.000000	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
55.01	05501 CYBERKNIFE	0.000000	0	0	0	0	55.01
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
65.01	03610 SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03020 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09001 OUTPATIENT CLINICS	0.008020	0	0	0	0	90.01
90.02	09003 OUTPATIENT SERVICES	0.000000	0	0	0	0	90.02
91.00	09100 EMERGENCY	0.000786	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: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 9:05 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		62,739	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		62,739	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)		56,665	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)		26,658	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		70,324,185	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)		70,324,185	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		70,324,185	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,120.90	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		29,880,952	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)		29,880,952	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 9:05 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital							
PPS							
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	15,133,612	9,786	1,546.46	2,028	3,136,221	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)					53,492,304	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					86,509,477	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)					5,984,539	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,014,289	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					8,998,828	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					77,510,649	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					6,074	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,120.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,808,347	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 9:05 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	12,534,930	70,324,185	0.178245	6,808,347	1,213,554	90.00
91.00	Nursing School cost	0	70,324,185	0.000000	6,808,347	0	91.00
92.00	Allied health cost	576,883	70,324,185	0.008203	6,808,347	55,849	92.00
93.00	All other Medical Education	0	70,324,185	0.000000	6,808,347	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 9:05 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			62,739 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			62,739 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)			56,665 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)			2,178 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)			6,476 15.00
16.00	Nursery days (title V or XIX only)			1,182 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			70,324,185 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)			70,324,185 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			70,324,185 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,120.90 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,441,320 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,441,320 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1	
		Title XIX		Hospital		Date/Time Prepared: 11/28/2018 9:05 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	3,884,999	6,476	599.91	1,182	709,094	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	15,133,612	9,786	1,546.46	124	191,761	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)					3,342,175	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)					6,074	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,120.90	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,808,347	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 9:05 am	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	12,534,930	70,324,185	0.178245	6,808,347	1,213,554	90.00
91.00	Nursing School cost	0	70,324,185	0.000000	6,808,347	0	91.00
92.00	Allied health cost	576,883	70,324,185	0.008203	6,808,347	55,849	92.00
93.00	All other Medical Education	0	70,324,185	0.000000	6,808,347	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 9:05 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		76,606,836		30.00
31.00	03100 INTENSIVE CARE UNIT		21,452,210		31.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.168535	44,819,180	7,553,601	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.211753	26,692	5,652	52.00
53.00	05300 ANESTHESIOLOGY	0.010349	18,381,774	190,233	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.101600	13,944,441	1,416,755	54.00
54.01	03630 ULTRASOUND	0.089789	2,388,252	214,439	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.173487	113,685	19,723	55.00
55.01	05501 CYBERKNIFE	0.239798	18,733	4,492	55.01
56.00	05600 RADIOISOTOPE	0.168001	2,351,422	395,041	56.00
57.00	05700 CT SCAN	0.019602	17,330,975	339,722	57.00
58.00	05800 MRI	0.036506	4,528,212	165,307	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.071501	11,929,095	852,942	59.00
60.00	06000 LABORATORY	0.059110	27,535,335	1,627,614	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.120910	17,352,488	2,098,089	65.00
65.01	03610 SLEEP LAB	0.099124	5,635	559	65.01
66.00	06600 PHYSICAL THERAPY	0.209359	6,012,327	1,258,735	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.189654	3,028,934	574,449	67.00
68.00	06800 SPEECH PATHOLOGY	0.160296	1,481,692	237,509	68.00
69.00	06900 ELECTROCARDIOLOGY	0.098352	5,932,496	583,473	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.104267	2,052,458	214,004	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.334306	27,185,195	9,088,174	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.324103	40,367,098	13,083,098	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.112391	92,383,585	10,383,084	73.00
74.00	07400 RENAL DIALYSIS	0.306016	2,138,563	654,434	74.00
76.00	03020 CARDIAC REHABILITATION	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.117574	110,551	12,998	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
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.497691	120,288	59,866	90.00
90.01	09001 OUTPATIENT CLINICS	0.354230	379,164	134,311	90.01
90.02	09003 OUTPATIENT SERVICES	0.293845	0	0	90.02
91.00	09100 EMERGENCY	0.080844	24,659,094	1,993,540	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.495762	666,570	330,460	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		367,243,934	53,492,304	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)		367,243,934		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 9:05 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		15,119,863	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		48,354,612	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0	1.04
2.00	Outlier payments for discharges. (see instructions)		2,422,800	2.00
2.01	Outlier reconciliation amount		0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2.02
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		265.36	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.87	30.00
31.00	Percentage of Medicaid patient days (see instructions)		11.34	31.00
32.00	Sum of lines 30 and 31		13.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00
34.00	Disproportionate share adjustment (see instructions)		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 9:05 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>Uncompensated Care Adjustment</b>				
35.00	Total uncompensated care amount (see instructions)	5,977,483,147	6,766,695,164	35.00
35.01	Factor 3 (see instructions)	0.000181923	0.000262424	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	0	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	0	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	0	0	36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	65,897,275		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)		65,897,275	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		5,664,331	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		90,365	53.00
54.00	Special add-on payments for new technologies		4,143	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).		277,476	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		25,134	58.00
59.00	Total (sum of amounts on lines 49 through 58)		71,958,724	59.00
60.00	Primary payer payments		12,694	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		71,946,030	61.00
62.00	Deductibles billed to program beneficiaries		6,204,536	62.00
63.00	Coinurance billed to program beneficiaries		194,468	63.00
64.00	Allowable bad debts (see instructions)		584,036	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		379,623	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		524,312	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		65,926,649	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)		211,544	70.93
70.94	HRR adjustment amount (see instructions)		-598,782	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 9:05 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
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	1.00	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)			65,539,411	71.00
71.01	Sequestration adjustment (see instructions)			1,310,788	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			63,729,155	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)			499,468	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,034,396	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)			0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)			0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
<b>Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment</b>					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
<b>Cost Reimbursement</b>					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
<b>Comparison of PPS versus Cost Reimbursement</b>					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0200

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/28/2018 9:05 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	15,119,863	0	15,119,863		15,119,863	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	48,354,612	0		48,354,612	48,354,612	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	2,422,800	0	656,662	1,766,138	2,422,800	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	65,897,275	0	15,776,525	50,120,750	65,897,275	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	65,897,275	0	15,776,525	50,120,750	65,897,275	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,664,331	0	1,322,314	4,342,017	5,664,331	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	0	4,143	0	4,143	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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0200

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

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
11/28/2018 9:05 am

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	17,102,982	54,462,767	71,565,749	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	5,162,375	0	1,224,006	3,938,369	5,162,375	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	361,539	0	65,015	296,524	361,539	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0272	0.0272	0.0272	0.0272		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	140,417	0	33,293	107,124	140,417	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,664,331	0	1,322,314	4,342,017	5,664,331	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5		Provider CCN: 14-0200		Period: From 07/01/2017 To 06/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/28/2018 9:05 am	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 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	15,119,863	15,119,863		15,119,863	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	48,354,612		48,354,612	48,354,612	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	2,422,800	656,662	1,766,138	2,422,800	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	65,897,275	15,776,525	50,120,750	65,897,275	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	65,897,275	15,776,525	50,120,750	65,897,275	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,664,331	1,322,314	4,342,017	5,664,331	16.00
17.00	Special add-on payments for new technologies	54.00	4,143	4,143	0	4,143	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			17,102,982	54,462,767	71,565,749	19.00

		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	5,162,375	1,224,006	3,938,369	5,162,375	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	361,539	65,015	296,524	361,539	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0272	0.0272	0.0272		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	140,417	33,293	107,124	140,417	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,664,331	1,322,314	4,342,017	5,664,331	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	211,544	84,631	126,913	211,544	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	-598,782	-110,404	-488,378	-598,782	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: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 9:05 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		64,307	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		48,028,581	2.00
3.00	OPPS payments		46,592,721	3.00
4.00	Outlier payment (see instructions)		393,446	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		61,525	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		64,307	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		508,218	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)		508,218	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		508,218	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		443,911	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)		64,307	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)		47,047,692	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		87	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		8,878,374	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)		38,233,538	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)		38,233,538	30.00
31.00	Primary payer payments		9,130	31.00
32.00	Subtotal (line 30 minus line 31)		38,224,408	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		824,186	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		535,721	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		701,519	36.00
37.00	Subtotal (see instructions)		38,760,129	37.00
38.00	MSP-LCC reconciliation amount from PS&R		101	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)		36,367	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		38,760,028	40.00
40.01	Sequestration adjustment (see instructions)		775,201	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		37,789,700	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		195,127	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0200

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

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/28/2018 9:05 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		63,460,987		37,383,973	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		327,579		426,914	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	01/11/2018	59,411	01/11/2018	21,187	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)		-59,411		-21,187	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)		63,729,155		37,789,700	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		499,468		195,127	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		64,228,623		37,984,827	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/28/2018 9:05 am
		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 IPSS & 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: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 11/28/2018 9:05 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		3,342,175		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)		3,342,175	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)		3,342,175	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
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
<b>CUSTOMARY CHARGES</b>					
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)		3,342,175	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
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
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
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		3,342,175	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	Coinurance		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

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

Provider CCN: 14-0200

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

Worksheet G

Date/Time Prepared:  
11/28/2018 9:05 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	2,048,451	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	54,685,429	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	10,954,666	0	0	0	7.00
8.00	Prepaid expenses	3,396,454	0	0	0	8.00
9.00	Other current assets	611,952	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	71,696,952	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	31,291,564	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	463,031,624	0	0	0	15.00
16.00	Accumulated depreciation	-330,553,553	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	228,923,728	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	392,693,363	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	5,140,113	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	3,893,327	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,033,440	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	473,423,755	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	11,862,224	0	0	0	37.00
38.00	Salaries, wages, and fees payable	17,499,409	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	93,779,329	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	123,140,962	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	40,826,699	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	40,826,699	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	163,967,661	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	309,456,094				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	309,456,094	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	473,423,755	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0200

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

Worksheet G-1

Date/Time Prepared:  
11/28/2018 9:05 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		341,940,230		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		11,472,960			2.00
3.00	Total (sum of line 1 and line 2)		353,413,190		0	3.00
4.00	TEMP RESTRICTED NET ASSETS	2,114,760		0		4.00
5.00	PERM RESTRICTED NET ASSETS	489,515		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)		2,604,275		0	10.00
11.00	Subtotal (line 3 plus line 10)		356,017,465		0	11.00
12.00	TRANSFERS TO AFFILIATES	16,899,450		0		12.00
13.00	OTHER TRANSFERS	29,661,921		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)		46,561,371		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		309,456,094		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	TEMP RESTRICTED NET ASSETS		0			4.00
5.00	PERM RESTRICTED NET ASSETS		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	TRANSFERS TO AFFILIATES		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: 14-0200

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

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/28/2018 9:05 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	186,001,796		186,001,796	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	186,001,796		186,001,796	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	43,082,168		43,082,168	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)	43,082,168		43,082,168	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	229,083,964		229,083,964	17.00
18.00	Ancillary services	917,467,909	0	917,467,909	18.00
19.00	Outpatient services	0	1,333,931,429	1,333,931,429	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	NURSERY	21,933,528	0	21,933,528	27.00
27.01	PROFESSIONAL FEES	3,209,353	18,810,745	22,020,098	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	1,171,694,754	1,352,742,174	2,524,436,928	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		461,521,510		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		461,521,510		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0200

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

Worksheet G-3

Date/Time Prepared:  
11/28/2018 9:05 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	2,524,436,928	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,072,288,011	2.00
3.00	Net patient revenues (line 1 minus line 2)	452,148,917	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	461,521,510	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-9,372,593	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	501,649	6.00
7.00	Income from investments	500,005	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	34,201	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	2,278,736	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	REFERENCE LAB	5,770,661	24.00
24.01	MGMT FEES	0	24.01
24.02	RENTAL INCOME	2,146,828	24.02
24.03	IHP DISTRIBUTIONS	403,834	24.03
24.04	APN'S	0	24.04
24.05	GRANTS	134,956	24.05
24.06	SCHOOL NURSES	0	24.06
24.07	UNREALIZED	21,027	24.07
24.08	GAIN ON SALE OF ASSETS	-68,403	24.08
24.09	OTHER REVENUE	3,837,545	24.09
24.10	INTERCO REV	1,995,289	24.10
24.11	INVESTMENTS INCOME FROM AFFILIATES	800,507	24.11
24.12	RESEARCH	32,170	24.12
24.13	OCCUPATIONAL HEALTH	1,156,029	24.13
24.14	OTHER COMMUNITY REV	1,290,410	24.14
24.15	RENTAL INCOME	10,109	24.15
25.00	Total other income (sum of lines 6-24)	20,845,553	25.00
26.00	Total (line 5 plus line 25)	11,472,960	26.00
27.00	ROUNDING	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	11,472,960	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0200	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/28/2018 9:05 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		5,162,375	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		361,539	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)		182.06	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		1.87	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		11.34	8.00
9.00	Sum of lines 7 and 8		13.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)		2.72	10.00
11.00	Disproportionate share adjustment (see instructions)		140,417	11.00
12.00	Total prospective capital payments (see instructions)		5,664,331	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00