

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: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/28/2018 2:38 pm
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PART I - COST REPORT STATUS

Provider use only 1. Electronically filed cost report Date: 11/28/2018 Time: 2:38 pm
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

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

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)
 I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PRESENCE SAINT JOSEPH HOSPITAL ELGIN (14-0217) for the cost reporting period beginning 01/01/2018 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) KEVIN LARKIN
 Officer or Administrator of Provider(s)
 CHIEF FINANCIAL OFFICER
 Title
 (Dated when report is electronically signed.)
 Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	56,295	13,220	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	-26,955	1		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	29,340	13,221	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: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:09 am				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60123 County: KANE				
1.00 Street: 77 NORTH AIRLITE ST.		2.00 City: ELGIN								
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		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	PRESENCE SAINT JOSEPH HOSPITAL ELGIN	140217	20994	1	09/01/1966	N	P	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF	PRESENCE SAINT JOSEPH REHAB UNIT	14T217	16974	5	09/01/1997	N	P	N	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)					01/01/2018	06/30/2018		20.00	
21.00	Type of Control (see instructions)					1			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						2		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.	1,871	309	0	0	341	185		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 but unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:09 am			
		Urban/Rural St	Date of Geogra				
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00		
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00		
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00		
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00		
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0			37.00		
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)				37.01		
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.				38.00		
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N		39.00		
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40.00		
		V	XVIII	XIX			
		1.00	2.00	3.00			
Prospective Payment System (PPS)-Capital							
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00		
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00		
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00		
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00		
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	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 Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y				60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03

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	Y/N	IME	Direct GME	IME	Direct GME			
	1.00	2.00	3.00	4.00	5.00			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06	
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00		2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.10	0.00 0.00
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						61.20	0.00 0.00
							1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)						62.00	0.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)						62.01	0.00
Teaching Hospitals that Claim Residents in Nonprovider Settings								
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						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.			Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N		0	76.00

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			1.00	
Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00
TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
			V 1.00	XIX 2.00
Title V and XIX Services				
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?		N	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N	108.00
			Physical 1.00	Occupational 2.00
			Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N		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: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/28/2018 10:09 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	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	702,764	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.	Y		5.05	122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		14H082	140.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 10:09 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/12/2018			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			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y			12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N			13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N			14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N			15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/05/2018	Y	11/05/2018		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/28/2018 10:09 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	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00		2.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PATRICK		GILLI LAND	41.00
42.00	Enter the employer/company name of the cost report preparer	PRESENCE HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(847)813-3718		PATRICK.GILLI LAND@AMI TAHEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0217

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

Worksheet S-2
Part II
Date/Time Prepared:
11/28/2018 10:09 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 10:09 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	129	23,349	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)		129	23,349	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	2,715	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		144	26,064	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	40	7,240		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
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)		184				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: 14-0217

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 10:09 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)	4,973	867	12,871			1.00
2.00	HMO and other (see instructions)	998	1,832				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	147	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	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,973	867	12,871			7.00
8.00	INTENSIVE CARE UNIT	545	7	552			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)	5,518	874	13,423	0.00	519.88	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	4,892	0	5,858	0.00	51.32	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	571.20	27.00
28.00	Observation Bed Days		211	1,341			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0217

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

Worksheet S-3
Part I
Date/Time Prepared:
11/28/2018 10:09 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	1,227	624	3,008	1.00
2.00	HMO and other (see instructions)			239	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,227	624	3,008	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	435	0	513	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: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet S-3 Part II Date/Time Prepared: 11/28/2018 10:09 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		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	19,785,088	0	19,785,088	594,046.03	33.31	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FOHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		1,924,852	30,877	1,955,729	58,079.64	33.67	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract Labor: Direct Patient Care		1,805,882	0	1,805,882	41,462.23	43.55	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		311,818	0	311,818	2,459.00	126.81	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		6,189,083	0	6,189,083	156,999.00	39.42	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		4,935,451	0	4,935,451			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		536,499	0	536,499			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		1,367,156	0	1,367,156			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	112,701	28,092	140,793	3,120.00	45.13	26.00
27.00	Administrative & General	5.00	1,045,092	0	1,045,092	33,223.62	31.46	27.00
28.00	Administrative & General under contract (see inst.)		1,799,780	0	1,799,780	9,707.00	185.41	28.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0217

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

Worksheet S-3
Part II
Date/Time Prepared:
11/28/2018 10:09 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	
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	670,281	0	670,281	26,356.69	25.43	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	553,502	0	553,502	37,620.99	14.71	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	464,406	-190,980	273,426	17,504.00	15.62	34.00
35.00	Dietary under contract (see instructions)		366,173	0	366,173	7,463.00	49.07	35.00
36.00	Cafeteria	11.00	0	190,980	190,980	12,226.00	15.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,120,523	-9	1,120,514	25,835.02	43.37	38.00
39.00	Central Services and Supply	14.00	197,289	0	197,289	8,984.02	21.96	39.00
40.00	Pharmacy	15.00	924,595	0	924,595	19,737.06	46.85	40.00
41.00	Medical Records & Medical Records Library	16.00	187,752	0	187,752	4,051.67	46.34	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: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet S-3 Part III Date/Time Prepared: 11/28/2018 10:09 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	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	21,951,041	0	21,951,041	611,216.03	35.91	1.00
2.00	Excluded area salaries (see instructions)	1,924,852	30,877	1,955,729	58,079.64	33.67	2.00
3.00	Subtotal salaries (line 1 minus line 2)	20,026,189	-30,877	19,995,312	553,136.39	36.15	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,306,783	0	8,306,783	200,920.23	41.34	4.00
5.00	Subtotal wage-related costs (see inst.)	6,302,607	0	6,302,607	0.00	31.52	5.00
6.00	Total (sum of lines 3 thru 5)	34,635,579	-30,877	34,604,702	754,056.62	45.89	6.00
7.00	Total overhead cost (see instructions)	7,442,094	28,083	7,470,177	205,829.07	36.29	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 11/28/2018 10:09 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			786,396 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)			957,046 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			1,909,427 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			0 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			46,134 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			11,680 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)			63,691 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			229,541 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			1,398,586 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			20,062 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			49,386 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			5,471,949 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet S-3 Part V Date/Time Prepared: 11/28/2018 10:09 am
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,805,882	5,471,950	1.00
2.00	Hospital	1,805,882	4,935,451	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF	0	486,879	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	49,620	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet S-10 Date/Time Prepared: 11/28/2018 10:09 am
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			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.170261	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		5,851,371	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			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		67,405,412	6.00
7.00	Medicaid cost (line 1 times line 6)		11,476,513	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		5,625,142	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		5,625,142	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)	9,600,644	537,651	10,138,295
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,634,615	537,651	2,172,266
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)	1,634,615	537,651	2,172,266
				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)		3,078,375	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		176,594	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		271,683	27.01
28.00	Non-Medicare bad debt expense (see instructions)		2,806,692	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		572,959	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		2,745,225	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		8,370,367	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0217

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

Worksheet A

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	1,844,105	1,844,105	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,716,095	1,716,095	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	112,701	-280,127	-167,426	27,768	-139,658	4.00
5.01	01160	COMMUNICATIONS	64,644	116,497	181,141	-2,953	178,188	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	29,083	29,083	-84	28,999	5.02
5.03	00570	ADMINISTRATIVE	0	0	0	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	980,448	15,951,596	16,932,044	-648,177	16,283,867	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	829,388	829,388	-41,374	788,014	6.00
7.00	00700	OPERATION OF PLANT	670,281	1,855,886	2,526,167	-248,660	2,277,507	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	182,635	182,635	-64,158	118,477	8.00
9.00	00900	HOUSEKEEPING	553,502	311,960	865,462	-17,613	847,849	9.00
10.00	01000	DIETARY	464,406	898,695	1,363,101	-580,731	782,370	10.00
11.00	01100	CAFETERIA	0	0	0	560,555	560,555	11.00
13.00	01300	NURSING ADMINISTRATION	1,120,523	641,501	1,762,024	-228,126	1,533,898	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	197,289	105,973	303,262	-108,409	194,853	14.00
15.00	01500	PHARMACY	924,595	4,542,386	5,466,981	-4,026,098	1,440,883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	187,752	90,802	278,554	0	278,554	16.00
23.00	02300	PARAMEDICAL PRGM-AMBULANCE	100,672	42,580	143,252	30,288	173,540	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,706,187	1,425,478	6,131,665	-333,679	5,797,986	30.00
31.00	03100	INTENSIVE CARE UNIT	993,282	728,905	1,722,187	-161,348	1,560,839	31.00
41.00	04100	SUBPROVIDER - IIRF	1,775,409	2,174,477	3,949,886	-96,982	3,852,904	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	948,434	6,740,382	7,688,816	-6,134,694	1,554,122	50.00
51.00	05100	RECOVERY ROOM	921,386	324,098	1,245,484	-107,013	1,138,471	51.00
53.00	05300	ANESTHESIOLOGY	36,009	1,045,748	1,081,757	-82,366	999,391	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,070,566	1,519,596	2,590,162	-1,129,697	1,460,465	54.00
54.01	03650	VASCULAR LAB	193,535	69,569	263,104	-31,678	231,426	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	452,027	653,007	1,105,034	-122,417	982,617	55.00
57.00	05700	CT SCAN	197,082	96,166	293,248	-17,095	276,153	57.00
58.00	05800	MRI	100,802	99,661	200,463	-16,647	183,816	58.00
59.00	05900	CARDIAC CATHETERIZATION	530,676	2,667,208	3,197,884	-2,449,852	748,032	59.00
60.00	06000	LABORATORY	46,743	2,463,789	2,510,532	-117,024	2,393,508	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	224,832	224,832	-224,879	-47	62.00
65.00	06500	RESPIRATORY THERAPY	471,114	203,224	674,338	-73,715	600,623	65.00
66.00	06600	PHYSICAL THERAPY	1,384	955,541	956,925	-9,997	946,928	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	502	502	-252	250	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,468	1,468	-1,394	74	68.00
69.00	06900	ELECTROCARDIOLOGY	278,212	115,871	394,083	-33,152	360,931	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,848,083	5,848,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,991,024	3,991,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,393,859	4,393,859	73.00
74.00	07400	RENAL DIALYSIS	0	285,205	285,205	-14,359	270,846	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	161,110	45,070	206,180	-3	206,177	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	96,234	64,851	161,085	-11,116	149,969	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	42,401	537,886	580,287	-144,829	435,458	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,190,233	1,482,455	2,672,688	-212,820	2,459,868	91.00
91.01	09101	CIVIL OUT	11,703	150,216	161,919	-436	161,483	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	134,975	87,531	222,506	-242	222,264	91.03
91.04	09104	HUNTLEY OP	0	684	684	0	684	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	909,546	909,546	-909,546	0	113.00
118.00	11800	SUBTOTALS (SUM OF LINES 1 through 117)	19,736,317	50,391,821	70,128,138	8,162	70,136,300	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	38,618	38,618	-8,162	30,456	194.01
194.02	07952	COMMUNITY WELLNESS	48,771	9,717	58,488	0	58,488	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	490	490	0	490	194.04
200.00	20000	TOTAL (SUM OF LINES 118 through 199)	19,785,088	50,440,646	70,225,734	0	70,225,734	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0217

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

Worksheet A
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	467,421	2,311,526	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	266,269	1,982,364	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	94,572	-45,086	4.00
5.01	01160	COMMUNICATIONS	-10,369	167,819	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	28,999	5.02
5.03	00570	ADMINISTRATIVE	0	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,032,208	2,032,208	5.04
5.05	00590	OTHER ADMIN AND GENERAL	3,587,012	19,870,879	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	788,014	6.00
7.00	00700	OPERATION OF PLANT	0	2,277,507	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	118,477	8.00
9.00	00900	HOUSEKEEPING	0	847,849	9.00
10.00	01000	DIETARY	0	782,370	10.00
11.00	01100	CAFETERIA	-277,780	282,775	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,533,898	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	128,167	323,020	14.00
15.00	01500	PHARMACY	0	1,440,883	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	700,891	979,445	16.00
23.00	02300	PARAMED PRGM-AMBULANCE	-21,674	151,866	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-44,449	5,753,537	30.00
31.00	03100	INTENSIVE CARE UNIT	-103,732	1,457,107	31.00
41.00	04100	SUBPROVIDER - IRF	0	3,852,904	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	1,554,122	50.00
51.00	05100	RECOVERY ROOM	0	1,138,471	51.00
53.00	05300	ANESTHESIOLOGY	-945,750	53,641	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-59,621	1,400,844	54.00
54.01	03650	VASCULAR LAB	0	231,426	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	-386	982,231	55.00
57.00	05700	CT SCAN	0	276,153	57.00
58.00	05800	MRI	0	183,816	58.00
59.00	05900	CARDIAC CATHETERIZATION	-38,803	709,229	59.00
60.00	06000	LABORATORY	18,328	2,411,836	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	-47	62.00
65.00	06500	RESPIRATORY THERAPY	0	600,623	65.00
66.00	06600	PHYSICAL THERAPY	0	946,928	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	250	67.00
68.00	06800	SPEECH PATHOLOGY	0	74	68.00
69.00	06900	ELECTROCARDIOLOGY	0	360,931	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,848,083	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,991,024	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,393,859	73.00
74.00	07400	RENAL DIALYSIS	0	270,846	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	206,177	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	149,969	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	435,458	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0	0	90.01
91.00	09100	EMERGENCY	-935,336	1,524,532	91.00
91.01	09101	CVILLE OUT	-36,885	124,598	91.01
91.02	09102	LAKE HILL OUT	0	0	91.02
91.03	09103	NUTRITION COUNSELING	-59,508	162,756	91.03
91.04	09104	HUNTLEY OP	0	684	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,760,575	74,896,875	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	194.00
194.01	07951	MOB	0	30,456	194.01
194.02	07952	COMMUNITY WELLNESS	0	58,488	194.02
194.03	07953	FUND DEVELOPMENT	0	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	490	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	4,760,575	74,986,309	200.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6
Date/Time Prepared:
11/28/2018 10:09 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - CAFETERIA					
1.00	CAFETERIA	11.00	190,980	369,575	1.00
	O		190,980	369,575	
B - EQUIP DEPR					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,716,095	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	949,469	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
	O		0	2,665,564	
D - DIRECTLY ASSIGNED DEPR					
1.00	CIVILLE OUT	91.01	0	14,910	1.00
	O		0	14,910	
H - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	909,546	1.00
	O		0	909,546	
I - EMS TRAINING COSTS					
1.00	PARAMED ED PRGM-AMBULANCE	23.00	31,440	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	O		31,440	0	
J - DEFERRED COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	28,092	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	O		28,092	0	
K - DRUG COSTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	4,263,168	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6

Date/Time Prepared:
11/28/2018 10:09 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
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
0			0	4,263,168		
L - IMPLANTS						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,991,024		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
0			0	3,991,024		
M - BILLABLE SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	5,848,083		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00		0.00	0	0		33.00
0			0	5,848,083		
N - RECLASS OP PROCEDURE COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	99,958	30,733		1.00
2.00		0.00	0	0		2.00
0			99,958	30,733		

Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet A-6 Date/Time Prepared: 11/28/2018 10:09 am
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Increases				
Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00	
500.00	Grand Total : Increases	350,470	18,092,603	500.00

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6
Date/Time Prepared:
11/28/2018 10:09 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA						
1.00 DIETARY	10.00	190,980	369,575	0	1.00	
O		190,980	369,575			
B - EQUIP DEPR						
1.00 EMPLOYEE BENEFITS DEPARTMENT	4.00	0	324	9	1.00	
2.00 COMMUNICATIONS	5.01	0	2,949	9	2.00	
3.00 PURCHASING RECEIVING AND STORES	5.02	0	76	0	3.00	
4.00 OTHER ADMIN AND GENERAL	5.05	0	648,177	0	4.00	
5.00 MAINTENANCE & REPAIRS	6.00	0	40,392	0	5.00	
6.00 OPERATION OF PLANT	7.00	0	244,392	0	6.00	
7.00 HOUSEKEEPING	9.00	0	969	0	7.00	
8.00 DIETARY	10.00	0	16,400	0	8.00	
9.00 NURSING ADMINISTRATION	13.00	0	226,661	0	9.00	
10.00 CENTRAL SERVICES & SUPPLY	14.00	0	12,329	0	10.00	
11.00 PHARMACY	15.00	0	2,829	0	11.00	
12.00 PARAMED ED PRGM-AMBULANCE	23.00	0	1,152	0	12.00	
13.00 ADULTS & PEDIATRICS	30.00	0	9,849	0	13.00	
14.00 INTENSIVE CARE UNIT	31.00	0	35,661	0	14.00	
15.00 SUBPROVIDER - IRF	41.00	0	16,691	0	15.00	
16.00 OPERATING ROOM	50.00	0	156,355	0	16.00	
17.00 RECOVERY ROOM	51.00	0	231	0	17.00	
18.00 ANESTHESIOLOGY	53.00	0	11,060	0	18.00	
19.00 RADIOLOGY-DIAGNOSTIC	54.00	0	977,496	0	19.00	
20.00 VASCULAR LAB	54.01	0	4,470	0	20.00	
21.00 RADIOLOGY-THERAPEUTIC	55.00	0	38,028	0	21.00	
22.00 CT SCAN	57.00	0	879	0	22.00	
23.00 MRI	58.00	0	9,624	0	23.00	
24.00 CARDIAC CATHETERIZATION	59.00	0	81,441	0	24.00	
25.00 LABORATORY	60.00	0	44,337	0	25.00	
26.00 RESPIRATORY THERAPY	65.00	0	4,816	0	26.00	
27.00 PHYSICAL THERAPY	66.00	0	2,625	0	27.00	
28.00 SPEECH PATHOLOGY	68.00	0	1,394	0	28.00	
29.00 ELECTROCARDIOLOGY	69.00	0	16,044	0	29.00	
30.00 CARDIAC REHABILITATION	76.97	0	3,075	0	30.00	
31.00 HYPERBARIC OXYGEN THERAPY	76.98	0	794	0	31.00	
32.00 EMERGENCY	91.00	0	30,972	0	32.00	
33.00 CIVIL OUT	91.01	0	14,910	0	33.00	
34.00 MOB	194.01	0	8,162	0	34.00	
O		0	2,665,564			
D - DIRECTLY ASSIGNED DEPR						
1.00 CAP REL COSTS-BLDG & FIXT	1.00	0	14,910	9	1.00	
O		0	14,910			
H - INTEREST EXPENSE						
1.00 INTEREST EXPENSE	113.00	0	909,546	11	1.00	
O		0	909,546			
I - EMS TRAINING COSTS						
1.00 ADULTS & PEDIATRICS	30.00	1,194	0	0	1.00	
2.00 INTENSIVE CARE UNIT	31.00	3,380	0	0	2.00	
3.00 OPERATING ROOM	50.00	2,141	0	0	3.00	
4.00 ANESTHESIOLOGY	53.00	2,347	0	0	4.00	
5.00 EMERGENCY	91.00	22,378	0	0	5.00	
O		31,440	0			
J - DEFERRED COMPENSATION						
1.00 NURSING ADMINISTRATION	13.00	9	0	0	1.00	
2.00 ADULTS & PEDIATRICS	30.00	415	0	0	2.00	
3.00 INTENSIVE CARE UNIT	31.00	316	0	0	3.00	
4.00 SUBPROVIDER - IRF	41.00	563	0	0	4.00	
5.00 OPERATING ROOM	50.00	737	0	0	5.00	
6.00 RADIOLOGY-THERAPEUTIC	55.00	2,900	0	0	6.00	
7.00 CARDIAC CATHETERIZATION	59.00	5,000	0	0	7.00	
8.00 CARDIAC REHABILITATION	76.97	7,500	0	0	8.00	
9.00 EMERGENCY	91.00	10,652	0	0	9.00	
O		28,092	0			
K - DRUG COSTS						
1.00 OPERATION OF PLANT	7.00	0	2,403	0	1.00	
2.00 PHARMACY	15.00	0	3,997,017	0	2.00	
3.00 ADULTS & PEDIATRICS	30.00	0	44,440	0	3.00	
4.00 INTENSIVE CARE UNIT	31.00	0	15,134	0	4.00	
5.00 SUBPROVIDER - IRF	41.00	0	3,673	0	5.00	
6.00 OPERATING ROOM	50.00	0	18,885	0	6.00	
7.00 RECOVERY ROOM	51.00	0	33,231	0	7.00	
8.00 ANESTHESIOLOGY	53.00	0	11,700	0	8.00	
9.00 RADIOLOGY-DIAGNOSTIC	54.00	0	6,901	0	9.00	

RECLASSIFICATIONS

Provider CCN: 14-0217

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

Worksheet A-6
Date/Time Prepared:
11/28/2018 10:09 am

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
6.00	7.00	8.00	9.00	10.00			
10.00	VASCULAR LAB	54.01	0	4,466	0	10.00	
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	8,036	0	11.00	
12.00	CT SCAN	57.00	0	3,394	0	12.00	
13.00	MRI	58.00	0	6,218	0	13.00	
14.00	CARDIAC CATHETERIZATION	59.00	0	6,335	0	14.00	
15.00	LABORATORY	60.00	0	29,367	0	15.00	
16.00	RESPIRATORY THERAPY	65.00	0	3,579	0	16.00	
17.00	PHYSICAL THERAPY	66.00	0	3	0	17.00	
18.00	ELECTROCARDIOLOGY	69.00	0	9,366	0	18.00	
19.00	RENAL DIALYSIS	74.00	0	14,359	0	19.00	
20.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.02	0	3	0	20.00	
21.00	HYPERBARIC OXYGEN THERAPY	76.98	0	557	0	21.00	
22.00	EMERGENCY	91.00	0	44,101	0	22.00	
0			0	4,263,168			
L - IMPLANTS							
1.00	HOUSEKEEPING	9.00	0	3,969	0	1.00	
2.00	DIETARY	10.00	0	41	0	2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,140	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	52	0	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	2,447	0	5.00	
6.00	SUBPROVIDER - IRF	41.00	0	1,254	0	6.00	
7.00	OPERATING ROOM	50.00	0	3,624,699	0	7.00	
8.00	RECOVERY ROOM	51.00	0	151	0	8.00	
9.00	ANESTHESIOLOGY	53.00	0	304	0	9.00	
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	219	0	10.00	
11.00	RADIOLOGY-THERAPEUTIC	55.00	0	766	0	11.00	
12.00	CT SCAN	57.00	0	4,035	0	12.00	
13.00	MRI	58.00	0	69	0	13.00	
14.00	CARDIAC CATHETERIZATION	59.00	0	244,286	0	14.00	
15.00	RESPIRATORY THERAPY	65.00	0	58	0	15.00	
16.00	ELECTROCARDIOLOGY	69.00	0	899	0	16.00	
17.00	HYPERBARIC OXYGEN THERAPY	76.98	0	99,199	0	17.00	
18.00	EMERGENCY	91.00	0	7,436	0	18.00	
0			0	3,991,024			
M - BILLABLE SUPPLIES							
1.00	COMMUNICATIONS	5.01	0	4	0	1.00	
2.00	PURCHASING RECEIVING AND STORES	5.02	0	8	0	2.00	
3.00	MAINTENANCE & REPAIRS	6.00	0	982	0	3.00	
4.00	OPERATION OF PLANT	7.00	0	1,865	0	4.00	
5.00	LAUNDRY & LINEN SERVICE	8.00	0	64,158	0	5.00	
6.00	HOUSEKEEPING	9.00	0	12,675	0	6.00	
7.00	DIETARY	10.00	0	3,735	0	7.00	
8.00	NURSING ADMINISTRATION	13.00	0	1,456	0	8.00	
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	94,940	0	9.00	
10.00	PHARMACY	15.00	0	26,252	0	10.00	
11.00	ADULTS & PEDIATRICS	30.00	0	148,877	0	11.00	
12.00	INTENSIVE CARE UNIT	31.00	0	102,571	0	12.00	
13.00	SUBPROVIDER - IRF	41.00	0	74,801	0	13.00	
14.00	OPERATING ROOM	50.00	0	2,331,877	0	14.00	
15.00	RECOVERY ROOM	51.00	0	73,400	0	15.00	
16.00	ANESTHESIOLOGY	53.00	0	56,955	0	16.00	
17.00	RADIOLOGY-DIAGNOSTIC	54.00	0	145,081	0	17.00	
18.00	VASCULAR LAB	54.01	0	22,742	0	18.00	
19.00	RADIOLOGY-THERAPEUTIC	55.00	0	72,687	0	19.00	
20.00	CT SCAN	57.00	0	8,787	0	20.00	
21.00	MRI	58.00	0	736	0	21.00	
22.00	CARDIAC CATHETERIZATION	59.00	0	2,112,790	0	22.00	
23.00	LABORATORY	60.00	0	43,320	0	23.00	
24.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	224,879	0	24.00	
25.00	RESPIRATORY THERAPY	65.00	0	65,262	0	25.00	
26.00	PHYSICAL THERAPY	66.00	0	7,369	0	26.00	
27.00	OCCUPATIONAL THERAPY	67.00	0	252	0	27.00	
28.00	ELECTROCARDIOLOGY	69.00	0	6,843	0	28.00	
29.00	CARDIAC REHABILITATION	76.97	0	541	0	29.00	
30.00	HYPERBARIC OXYGEN THERAPY	76.98	0	44,279	0	30.00	
31.00	EMERGENCY	91.00	0	97,281	0	31.00	
32.00	CIVIL OUT	91.01	0	436	0	32.00	
33.00	NUTRITION COUNSELING	91.03	0	242	0	33.00	
0			0	5,848,083			

RECLASSIFICATIONS		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet A-6 Date/Time Prepared: 11/28/2018 10:09 am
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Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.
	6.00	7.00	8.00	9.00	10.00
N - RECLASS OP PROCEDURE COSTS					
1.00	ADULTS & PEDIATRICS	30.00	98,897	29,955	0
2.00	INTENSIVE CARE UNIT	31.00	1,061	778	0
			99,958	30,733	
500.00	Grand Total: Decreases		350,470	18,092,603	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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

Worksheet A-7
Part I
Date/Time Prepared:
11/28/2018 10:09 am

	Beginning Balances	Acquisitions			Disposals and Retirements		
		Purchases	Donation	Total			
	1.00	2.00	3.00	4.00	5.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	2,549,055	2,470,945	0	2,470,945	0	1.00
2.00	Land Improvements	1,964,439	0	0	0	685,189	2.00
3.00	Buildings and Fixtures	46,912,256	982,970	0	982,970	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	854,282	10,384,954	0	10,384,954	0	5.00
6.00	Movable Equipment	17,619,853	0	0	0	16,710,239	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69,899,885	13,838,869	0	13,838,869	17,395,428	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	69,899,885	13,838,869	0	13,838,869	17,395,428	10.00
	Ending Balance		Fully Depreciated Assets				
	6.00		7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	5,020,000	0				1.00
2.00	Land Improvements	1,279,250	0				2.00
3.00	Buildings and Fixtures	47,895,226	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	11,239,236	0				5.00
6.00	Movable Equipment	909,614	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	66,343,326	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	66,343,326	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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

Worksheet A-7
Part II
Date/Time Prepared:
11/28/2018 10:09 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0217

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

Worksheet A-7
Part III
Date/Time Prepared:
11/28/2018 10:09 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	52,280,032	0	52,280,032	0.747927	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	17,619,853	0	17,619,853	0.252073	0	2.00
3.00	Total (sum of lines 1-2)	69,899,885	0	69,899,885	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	1,401,980	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,982,364	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,384,344	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	909,546	0	0	0	2,311,526	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,982,364	2.00
3.00	Total (sum of lines 1-2)	909,546	0	0	0	4,293,890	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0217

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

Worksheet A-8

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-10,369		COMMUNICATIONS	5.01	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	-2,726,793				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	6,517,214				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-234,818		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	B	-194		CAFETERIA	11.00	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	A	-154,684		CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	113,343		CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 HOME OFFICE INTEREST INCOME			0		0.00	0	33.00
34.01 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	34.01
34.02 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0	34.02

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0217

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

Worksheet A-8

Date/Time Prepared:
11/28/2018 10:09 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	
34.03 MISC REVENUE	B	-83,393	OTHER ADMIN AND GENERAL	5.05	0 34.03
34.05 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 34.05
34.06 MISC REVENUE		0		0.00	0 34.06
34.07 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 34.07
34.08 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 34.08
34.10 MISC REVENUE	B	-43,883	NUTRITION COUNSELING	91.03	0 34.10
35.00 SISTERS MEALS	A	-42,768	CAFETERIA	11.00	0 35.00
35.10 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 35.10
36.00 EMS	B	-21,674	PARAMED ED PRGM-AMBULANCE	23.00	0 36.00
37.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 37.00
38.00 EMPLOYEE ASSISTANCE PROGRAM	B	-44,249	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 38.00
39.00 PSYCH EDUCATION	B	-33,138	ADULTS & PEDIATRICS	30.00	0 39.00
40.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 40.00
41.00 RENT	B	-36,885	C'VILLE OUT	91.01	0 41.00
42.00 MISC REVENUE		0		0.00	0 42.00
43.00 MISC REVENUE		0		0.00	0 43.00
44.00 LOBBYING EXPENSE		0		0.00	0 44.00
45.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0 45.00
46.00 FAS 87 REV NEGATIVE EXP		0		0.00	0 46.00
47.00 ADD BACK DEPRECIATION ON IMPAIR	A	1,415,818	CAP REL COSTS-BLDG & FIXT	1.00	9 47.00
48.00 ADD BACK DEPRECIATION ON IMPAIR	A	147,048	CAP REL COSTS-MVBLE EQUIP	2.00	9 48.00
49.00 PENSION 3 EAR ADD BACK AND 10 YR AVE		0		0.00	0 49.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		4,760,575			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: 14-0217

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2018 10:09 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	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL-BLDG & FIXTURES	-793,713	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	138,821	0	2.00
3.00	5.05	OTHER ADMIN AND GENERAL	A&G	13,176,463	9,095,013	3.00
3.01	0.00			0	0	3.01
3.02	5.04	CASHIERING/ACCOUNTS RECEIVAB	PATIENT ACCOUNTING	2,032,208	0	3.02
3.03	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICES	128,167	0	3.03
3.04	31.00	INTENSIVE CARE UNIT	ICU	188,264	0	3.04
3.05	60.00	LABORATORY	LAB	2,297,084	2,266,138	3.05
3.06	2.00	CAP REL COSTS-MVBLE EQUIP	MEDICAL EQUIPMENT	5,878	0	3.06
4.00	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	705,193	0	4.00
4.02	0.00			0	0	4.02
4.03	0.00			0	0	4.03
4.04	0.00			0	0	4.04
4.05	0.00			0	0	4.05
4.06	0.00			0	0	4.06
4.07	0.00			0	0	4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,878,365	11,361,151	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		100.00	PRESENCE HEALTH	100.00	6.00
7.00	C		0.00	ALVERNO LABS	66.67	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0217

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

Worksheet A-8-1

Date/Time Prepared:
11/28/2018 10:09 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-793,713	9		1.00
2.00	138,821	0		2.00
3.00	4,081,450	0		3.00
3.01	0	0		3.01
3.02	2,032,208	0		3.02
3.03	128,167	9		3.03
3.04	188,264	0		3.04
3.05	30,946	0		3.05
3.06	5,878	9		3.06
4.00	705,193	0		4.00
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	0	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
5.00	6,517,214			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	HOME OFFICE		6.00
7.00	LABORATORY		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: 14-0217

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

Worksheet A-8-2

Date/Time Prepared:
11/28/2018 10:09 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	5.05	OTHER ADMIN AND GENERAL	452,328	401,591	50,737	211,500	406	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	13,250	0	13,250	211,500	88	2.00
3.00	30.00	ADULTS & PEDIATRICS	27,000	0	27,000	181,300	180	3.00
4.00	31.00	INTENSIVE CARE UNIT	291,996	291,996	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	38,400	0	38,400	181,300	480	5.00
6.00	53.00	ANESTHESIOLOGY	945,750	945,750	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	101,844	54,110	47,734	271,900	323	7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	67,577	0	67,577	271,900	514	8.00
9.00	59.00	CARDIAC CATHETERIZATION	38,803	38,803	0	0	0	9.00
10.00	60.00	LABORATORY	39,056	0	39,056	211,500	260	10.00
11.00	91.00	EMERGENCY	961,366	933,301	28,065	260,300	208	11.00
12.00	91.03	NUTRITION COUNSELING	15,625	15,625	0	0	0	12.00
200.00			2,992,995	2,681,176	311,819		2,459	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.05	OTHER ADMIN AND GENERAL	41,283	2,064	0	0	0	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	8,948	447	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	15,689	784	0	0	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	41,838	2,092	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	42,223	2,111	0	0	0	7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	67,191	3,360	0	0	0	8.00
9.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	9.00
10.00	60.00	LABORATORY	26,438	1,322	0	0	0	10.00
11.00	91.00	EMERGENCY	26,030	1,302	0	0	0	11.00
12.00	91.03	NUTRITION COUNSELING	0	0	0	0	0	12.00
200.00			269,640	13,482	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.05	OTHER ADMIN AND GENERAL	0	41,283	9,454	411,045	1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	8,948	4,302	4,302	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	15,689	11,311	11,311	3.00
4.00	31.00	INTENSIVE CARE UNIT	0	0	0	291,996	4.00
5.00	41.00	SUBPROVIDER - IRF	0	41,838	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	945,750	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	42,223	5,511	59,621	7.00
8.00	55.00	RADIOLOGY-THERAPEUTIC	0	67,191	386	386	8.00
9.00	59.00	CARDIAC CATHETERIZATION	0	0	0	38,803	9.00
10.00	60.00	LABORATORY	0	26,438	12,618	12,618	10.00
11.00	91.00	EMERGENCY	0	26,030	2,035	935,336	11.00
12.00	91.03	NUTRITION COUNSELING	0	0	0	15,625	12.00
200.00			0	269,640	45,617	2,726,793	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,311,526	2,311,526			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,982,364		1,982,364		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	-45,086	3,146	2,698	-39,242	4.00
5.01 01160	COMMUNICATIONS	167,819	19,038	16,327	0	203,184 5.01
5.02 00560	PURCHASING RECEIVING AND STORES	28,999	17,836	15,296	0	3,175 5.02
5.03 00570	ADMITTING	0	2,735	2,346	0	5,644 5.03
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	2,032,208	0	0	0	7,408 5.04
5.05 00590	OTHER ADMIN AND GENERAL	19,870,879	114,904	98,542	0	31,743 5.05
6.00 00600	MAINTENANCE & REPAIRS	788,014	240,344	206,119	0	353 6.00
7.00 00700	OPERATION OF PLANT	2,277,507	817,851	701,385	0	7,055 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	118,477	7,155	6,136	0	353 8.00
9.00 00900	HOUSEKEEPING	847,849	9,555	8,195	0	706 9.00
10.00 01000	DIETARY	782,370	68,578	58,813	0	4,586 10.00
11.00 01100	CAFETERIA	282,775	0	0	0	706 11.00
13.00 01300	NURSING ADMINISTRATION	1,533,898	5,712	4,898	0	7,408 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	323,020	26,652	22,857	0	1,764 14.00
15.00 01500	PHARMACY	1,440,883	9,082	7,789	0	2,469 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	979,445	23,752	20,369	0	7,055 16.00
23.00 02300	PARAMED ED PRGM-AMBULANCE	151,866	0	0	0	1,764 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,753,537	286,393	245,611	0	29,984 30.00
31.00 03100	INTENSIVE CARE UNIT	1,457,107	42,265	36,246	0	2,469 31.00
41.00 04100	SUBPROVIDER - IIRF	3,852,904	103,194	88,499	0	4,586 41.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,554,122	71,393	61,226	0	10,935 50.00
51.00 05100	RECOVERY ROOM	1,138,471	42,962	36,844	0	2,117 51.00
53.00 05300	ANESTHESIOLOGY	53,641	1,326	1,137	0	1,058 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,400,844	75,029	64,345	0	12,346 54.00
54.01 03650	VASCULAR LAB	231,426	5,511	4,727	0	353 54.01
55.00 05500	RADIOLOGY-THERAPEUTIC	982,231	106,820	91,609	0	10,935 55.00
57.00 05700	CT SCAN	276,153	5,563	4,771	0	0 57.00
58.00 05800	MRI	183,816	6,323	5,423	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	709,229	15,388	13,197	0	0 59.00
60.00 06000	LABORATORY	2,411,836	23,565	20,209	0	7,055 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	-47	3,805	3,264	0	353 62.00
65.00 06500	RESPIRATORY THERAPY	600,623	5,463	4,685	0	2,469 65.00
66.00 06600	PHYSICAL THERAPY	946,928	0	0	0	3,175 66.00
67.00 06700	OCCUPATIONAL THERAPY	250	30,088	25,804	0	353 67.00
68.00 06800	SPEECH PATHOLOGY	74	0	0	0	353 68.00
69.00 06900	ELECTROCARDIOLOGY	360,931	27,043	23,192	0	2,469 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,848,083	0	0	0	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	3,991,024	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	4,393,859	0	0	0	0 73.00
74.00 07400	RENAL DIALYSIS	270,846	2,096	1,798	0	0 74.00
76.00 03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0 76.00
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	206,177	9,003	7,721	0	5,997 76.02
76.03 03951	OCCUPATIONAL HEALTH	0	0	0	0	0 76.03
76.97 07697	CARDIAC REHABILITATION	149,969	2,669	2,289	0	0 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	435,458	0	0	0	0 76.98
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT PROCEDURES	0	0	0	0	0 90.01
91.00 09100	EMERGENCY	1,524,532	72,080	61,816	0	11,288 91.00
91.01 09101	CIVILLE OUT	124,598	0	0	0	353 91.01
91.02 09102	LAKE HILL OUT	0	0	0	0	0 91.02
91.03 09103	NUTRITION COUNSELING	162,756	0	0	0	0 91.03
91.04 09104	HUNTLEY OP	684	0	0	0	0 91.04
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	74,896,875	2,304,319	1,976,183	0	190,837 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,225	4,481	0	706 190.00
194.00 07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0 194.00
194.01 07951	MOB	30,456	0	0	0	10,230 194.01
194.02 07952	COMMUNITY WELLNESS	58,488	0	0	0	0 194.02
194.03 07953	FUND DEVELOPMENT	0	1,982	1,700	0	1,411 194.03
194.04 07954	PHYSICIAN PRACTICE MANAGEMENT	490	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	COMMUNICATIONS	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
201.00 Negative Cost Centers		0	0	-39,242	0	201.00
202.00 TOTAL (sum lines 118 through 201)	74,986,309	2,311,526	1,982,364	-39,242	203,184	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part I Date/Time Prepared: 11/28/2018 10:09 am	
Cost Center Description			PURCHASING RECEIVING AND STORES	ADMINITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMIN AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	65,306					5.02
5.03	00570	ADMINITTING	0	10,725				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	2,039,616			5.04
5.05	00590	OTHER ADMIN AND GENERAL	43	0	0	20,116,111	20,116,111	5.05
6.00	00600	MAINTENANCE & REPAIRS	10	0	0	1,234,840	452,385	6.00
7.00	00700	OPERATION OF PLANT	3,952	0	0	3,807,750	1,394,973	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	132,121	48,403	8.00
9.00	00900	HOUSEKEEPING	455	0	0	866,760	317,538	9.00
10.00	01000	DIETARY	795	0	0	915,142	335,263	10.00
11.00	01100	CAFETERIA	0	0	0	283,481	103,854	11.00
13.00	01300	NURSING ADMINISTRATION	668	0	0	1,552,584	568,791	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,139	0	0	376,432	137,906	14.00
15.00	01500	PHARMACY	1,381	0	0	1,461,604	535,460	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65	0	0	1,030,686	377,593	16.00
23.00	02300	PARAMED PRGM-AMBULANCE	967	0	0	154,597	56,637	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,277	1,469	249,896	6,575,167	2,408,800	30.00
31.00	03100	INTENSIVE CARE UNIT	2,079	255	49,271	1,589,692	582,385	31.00
41.00	04100	SUBPROVIDER - IIRF	4,510	485	93,795	4,147,973	1,519,614	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,436	1,187	229,580	1,936,879	709,578	50.00
51.00	05100	RECOVERY ROOM	1,195	471	91,014	1,313,074	481,046	51.00
53.00	05300	ANESTHESIOLOGY	176	224	43,300	100,862	36,951	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	984	366	70,807	1,624,721	595,218	54.00
54.01	03650	VASCULAR LAB	266	157	30,454	272,894	99,975	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	525	194	37,451	1,229,765	450,526	55.00
57.00	05700	CT SCAN	272	571	110,422	397,752	145,717	57.00
58.00	05800	MRI	47	162	31,299	227,070	83,187	58.00
59.00	05900	CARDIAC CATHETERIZATION	17,433	575	111,122	866,944	317,606	59.00
60.00	06000	LABORATORY	1,297	695	134,343	2,599,000	952,146	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1	19	3,700	11,095	4,065	62.00
65.00	06500	RESPIRATORY THERAPY	160	164	31,727	645,291	236,403	65.00
66.00	06600	PHYSICAL THERAPY	721	343	66,393	1,017,560	372,784	66.00
67.00	06700	OCCUPATIONAL THERAPY	20	143	27,701	84,359	30,905	67.00
68.00	06800	SPEECH PATHOLOGY	6	30	5,854	6,317	2,314	68.00
69.00	06900	ELECTROCARDIOLOGY	317	333	64,321	478,606	175,338	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	371	71,764	5,920,218	2,168,878	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	796	153,942	4,145,762	1,518,804	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	755	146,107	4,540,721	1,663,498	73.00
74.00	07400	RENAL DIALYSIS	0	34	6,552	281,326	103,064	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	106	20,432	249,436	91,381	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	82	20	3,777	158,806	58,179	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	2,939	103	19,883	458,383	167,929	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,985	682	131,930	1,805,313	661,378	91.00
91.01	09101	CVILLE OUT	2,064	10	1,891	128,916	47,229	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	39	5	888	163,688	59,967	91.03
91.04	09104	HUNTLEY OP	0	0	0	684	251	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	65,306	10,725	2,039,616	74,910,382	20,073,919	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	10,412	3,814	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	0	0	0	40,686	14,905	194.01
194.02	07952	COMMUNITY WELLNESS	0	0	0	58,488	21,427	194.02
194.03	07953	FUND DEVELOPMENT	0	0	0	5,093	1,866	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	490	180	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	-39,242	0	201.00
202.00		TOTAL (sum lines 118 through 201)	65,306	10,725	2,039,616	74,986,309	20,116,111	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600	1,687,225					6.00
7.00	00700	721,131	5,923,854				7.00
8.00	00800	6,309	38,685	225,518			8.00
9.00	00900	8,425	51,661	0	1,244,384		9.00
10.00	01000	60,468	370,775	0	79,093	1,760,741	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	5,036	30,881	0	6,587	0	13.00
14.00	01400	23,500	144,098	0	30,739	0	14.00
15.00	01500	8,008	49,103	0	10,475	0	15.00
16.00	01600	20,943	128,415	0	27,393	0	16.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	252,523	1,548,411	150,545	330,301	1,113,133	30.00
31.00	03100	37,266	228,507	6,456	48,744	14,150	31.00
41.00	04100	90,990	557,927	68,517	119,015	498,146	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	62,950	385,992	0	82,338	0	50.00
51.00	05100	37,881	232,278	0	49,549	5,817	51.00
53.00	05300	1,169	7,169	0	1,529	0	53.00
54.00	05400	66,156	405,652	0	86,532	0	54.00
54.01	03650	4,860	29,798	0	6,356	10,681	54.01
55.00	05500	94,187	577,531	0	123,197	13,334	55.00
57.00	05700	4,905	30,078	0	6,416	0	57.00
58.00	05800	5,575	34,185	0	7,292	0	58.00
59.00	05900	13,568	83,195	0	17,747	0	59.00
60.00	06000	20,778	127,407	0	27,178	0	60.00
62.00	06200	3,355	20,575	0	4,389	0	62.00
65.00	06500	4,817	29,537	0	6,301	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	26,530	162,675	0	34,701	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	23,844	146,208	0	31,189	0	69.00
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	1,848	11,333	0	2,418	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	7,938	48,674	0	10,383	71,737	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	2,354	14,432	0	3,079	0	76.97
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	63,556	389,707	0	83,131	33,743	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	0	0	0	0	0	91.03
91.04	09104	0	0	0	0	0	91.04
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,680,870	5,884,889	225,518	1,236,072	1,760,741	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	4,607	28,248	0	6,026	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	1,748	10,717	0	2,286	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,687,225	5,923,854	225,518	1,244,384	1,760,741	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0217

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

Worksheet B
Part I
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	387,335					11.00
13.00	01300	21,481	2,185,360				13.00
14.00	01400	7,470	53	720,198			14.00
15.00	01500	16,411	0	0	2,081,061		15.00
16.00	01600	3,369	832	0	0	1,589,231	16.00
23.00	02300	4,564	79	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	115,471	993,624	0	0	194,695	30.00
31.00	03100	20,433	193,716	0	0	38,391	31.00
41.00	04100	44,382	424,386	0	0	73,084	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	20,123	88,245	0	0	178,887	50.00
51.00	05100	20,722	180,676	0	0	70,917	51.00
53.00	05300	716	79	0	0	33,739	53.00
54.00	05400	23,759	28,531	0	0	55,172	54.00
54.01	03650	3,313	0	0	0	23,730	54.01
55.00	05500	9,596	33,662	0	0	29,182	55.00
57.00	05700	4,844	0	0	0	86,040	57.00
58.00	05800	1,719	0	0	0	24,388	58.00
59.00	05900	9,308	28,504	0	0	86,585	59.00
60.00	06000	908	0	0	0	104,679	60.00
62.00	06200	0	0	0	0	2,883	62.00
65.00	06500	10,812	0	0	0	24,722	65.00
66.00	06600	756	0	0	0	51,733	66.00
67.00	06700	0	0	0	0	21,585	67.00
68.00	06800	0	0	0	0	4,562	68.00
69.00	06900	6,683	6,436	0	0	50,119	69.00
71.00	07100	0	0	428,063	0	55,918	71.00
72.00	07200	0	0	292,135	0	119,950	72.00
73.00	07300	2,501	21,525	0	2,081,061	113,845	73.00
74.00	07400	0	0	0	0	5,106	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	4,019	5,675	0	0	15,920	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	2,174	8,074	0	0	2,943	76.97
76.98	07698	900	0	0	0	15,492	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	26,035	171,149	0	0	102,799	91.00
91.01	09101	616	0	0	0	1,473	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	3,372	0	0	0	692	91.03
91.04	09104	0	0	0	0	0	91.04
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		386,457	2,185,246	720,198	2,081,061	1,589,231	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	878	114	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		387,335	2,185,360	720,198	2,081,061	1,589,231	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part I Date/Time Prepared: 11/28/2018 10:09 am
Cost Center Description			PARAMED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01160	COMMUNICATIONS				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMINISTRATIVE				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER ADMIN AND GENERAL				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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
23.00	02300	PARAMED PRGM-AMBULANCE	215,877			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,666	13,692,336	0	30.00
31.00	03100	INTENSIVE CARE UNIT	22,554	2,782,294	0	31.00
41.00	04100	SUBPROVIDER - I RF	0	7,544,034	0	41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,464,992	0	50.00
51.00	05100	RECOVERY ROOM	0	2,391,960	0	51.00
53.00	05300	ANESTHESIOLOGY	16,110	198,324	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,885,741	0	54.00
54.01	03650	VASCULAR LAB	0	451,607	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,560,980	0	55.00
57.00	05700	CT SCAN	0	675,752	0	57.00
58.00	05800	MRI	0	383,416	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,423,457	0	59.00
60.00	06000	LABORATORY	0	3,832,096	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	46,362	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	957,883	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,442,833	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	360,755	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,193	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	918,423	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,573,077	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,076,651	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,423,151	0	73.00
74.00	07400	RENAL DIALYSIS	0	405,095	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	505,163	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0	250,041	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	642,704	0	76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	90.01
91.00	09100	EMERGENCY	161,103	3,497,914	0	91.00
91.01	09101	CVILLE OUT	0	178,234	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	0	227,719	0	91.03
91.04	09104	HUNTLEY OP	0	935	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	209,433	74,807,122	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	53,107	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	194.00
194.01	07951	MOB	0	55,591	0	194.01
194.02	07952	COMMUNITY WELLNESS	6,444	87,351	0	194.02
194.03	07953	FUND DEVELOPMENT	0	21,710	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	670	0	194.04
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	-39,242	0	201.00
202.00		TOTAL (sum lines 118 through 201)	215,877	74,986,309	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 10:09 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
		0	1.00				2.00	2A
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,298	3,146	2,698	7,142	7,142	4.00
5.01	01160	COMMUNICATIONS	11,333	19,038	16,327	46,698	0	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	17,836	15,296	33,132	0	5.02
5.03	00570	ADMITTING	0	2,735	2,346	5,081	0	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	0	0	5.04
5.05	00590	OTHER ADMIN AND GENERAL	32,108	114,904	98,542	245,554	0	5.05
6.00	00600	MAINTENANCE & REPAIRS	0	240,344	206,119	446,463	0	6.00
7.00	00700	OPERATION OF PLANT	1,308	817,851	701,385	1,520,544	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,155	6,136	13,291	0	8.00
9.00	00900	HOUSEKEEPING	672	9,555	8,195	18,422	0	9.00
10.00	01000	DIETARY	6,754	68,578	58,813	134,145	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,143	5,712	4,898	11,753	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,231	26,652	22,857	129,740	0	14.00
15.00	01500	PHARMACY	270,159	9,082	7,789	287,030	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	233	23,752	20,369	44,354	0	16.00
23.00	02300	PARAMED PRGM-AMBULANCE	982	0	0	982	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,134	286,393	245,611	536,138	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,448	42,265	36,246	80,959	0	31.00
41.00	04100	SUBPROVIDER - IRF	5,067	103,194	88,499	196,760	0	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,296	71,393	61,226	151,915	0	50.00
51.00	05100	RECOVERY ROOM	2,309	42,962	36,844	82,115	0	51.00
53.00	05300	ANESTHESIOLOGY	4	1,326	1,137	2,467	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,577	75,029	64,345	141,951	0	54.00
54.01	03650	VASCULAR LAB	0	5,511	4,727	10,238	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,919	106,820	91,609	201,348	0	55.00
57.00	05700	CT SCAN	138	5,563	4,771	10,472	0	57.00
58.00	05800	MRI	647	6,323	5,423	12,393	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,210	15,388	13,197	41,795	0	59.00
60.00	06000	LABORATORY	2,366	23,565	20,209	46,140	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	3,805	3,264	7,069	0	62.00
65.00	06500	RESPIRATORY THERAPY	7,771	5,463	4,685	17,919	0	65.00
66.00	06600	PHYSICAL THERAPY	38,785	0	0	38,785	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	30,088	25,804	55,892	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,558	27,043	23,192	52,793	0	69.00
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	2,096	1,798	3,894	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	672	9,003	7,721	17,396	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	32,431	2,669	2,289	37,389	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	34,616	0	0	34,616	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	11,718	72,080	61,816	145,614	0	91.00
91.01	09101	CIVILLE OUT	34,383	0	0	34,383	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	482	0	0	482	0	91.03
91.04	09104	HUNTLEY OP	684	0	0	684	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	625,436	2,304,319	1,976,183	4,905,938	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,225	4,481	9,706	0	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.01	07951	MOB	2,797	0	0	2,797	0	194.01
194.02	07952	COMMUNITY WELLNESS	1,021	0	0	1,021	0	194.02
194.03	07953	FUND DEVELOPMENT	0	1,982	1,700	3,682	0	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers				0	7,142	201.00

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
202.00	TOTAL (sum lines 118 through 201)	629,254	2,311,526	1,982,364	4,923,144	7,142	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 10:09 am	
Cost Center Description		COMMUNICATIONS	PURCHASING RECEIVING AND STORES	ADMINING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMIN AND GENERAL	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160	46,698					5.01
5.02	00560	730	33,862				5.02
5.03	00570	1,297	0	6,378			5.03
5.04	00580	1,703	0	0	1,703		5.04
5.05	00590	7,298	22	0	0	252,874	5.05
6.00	00600	81	5	0	0	5,686	6.00
7.00	00700	1,621	2,049	0	0	17,535	7.00
8.00	00800	81	0	0	0	608	8.00
9.00	00900	162	236	0	0	3,991	9.00
10.00	01000	1,054	412	0	0	4,214	10.00
11.00	01100	162	0	0	0	1,305	11.00
13.00	01300	1,703	346	0	0	7,150	13.00
14.00	01400	405	1,109	0	0	1,733	14.00
15.00	01500	568	716	0	0	6,731	15.00
16.00	01600	1,621	34	0	0	4,746	16.00
23.00	02300	405	501	0	0	712	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	6,891	4,292	595	161	30,297	30.00
31.00	03100	568	1,078	159	42	7,321	31.00
41.00	04100	1,054	2,338	303	81	19,101	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,513	4,374	742	198	8,919	50.00
51.00	05100	486	620	294	78	6,047	51.00
53.00	05300	243	91	140	37	464	53.00
54.00	05400	2,838	510	229	61	7,482	54.00
54.01	03650	81	138	98	26	1,257	54.01
55.00	05500	2,513	272	121	32	5,663	55.00
57.00	05700	0	141	357	95	1,832	57.00
58.00	05800	0	24	101	27	1,046	58.00
59.00	05900	0	9,041	359	96	3,992	59.00
60.00	06000	1,621	673	434	116	11,968	60.00
62.00	06200	81	0	12	3	51	62.00
65.00	06500	568	83	103	27	2,972	65.00
66.00	06600	730	374	215	57	4,686	66.00
67.00	06700	81	11	90	24	388	67.00
68.00	06800	81	3	19	5	29	68.00
69.00	06900	568	165	208	55	2,204	69.00
71.00	07100	0	0	232	62	27,263	71.00
72.00	07200	0	0	497	133	19,091	72.00
73.00	07300	0	0	472	126	20,910	73.00
74.00	07400	0	0	21	6	1,296	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	1,378	0	66	18	1,149	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	0	42	12	3	731	76.97
76.98	07698	0	1,524	64	17	2,111	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	2,594	1,548	426	114	8,313	91.00
91.01	09101	81	1,070	6	2	594	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	0	20	3	1	754	91.03
91.04	09104	0	0	0	0	3	91.04
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		43,861	33,862	6,378	1,703	252,345	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	162	0	0	0	48	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	2,351	0	0	0	187	194.01
194.02	07952	0	0	0	0	269	194.02
194.03	07953	324	0	0	0	23	194.03
194.04	07954	0	0	0	0	2	194.04
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		46,698	33,862	6,378	1,703	252,874	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 10:09 am	
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600	452,235					6.00
7.00	00700	193,290	1,735,039				7.00
8.00	00800	1,691	11,330	27,001			8.00
9.00	00900	2,258	15,131	0	40,200		9.00
10.00	01000	16,208	108,596	0	2,555	267,184	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	1,350	9,045	0	213	0	13.00
14.00	01400	6,299	42,205	0	993	0	14.00
15.00	01500	2,146	14,382	0	338	0	15.00
16.00	01600	5,613	37,611	0	885	0	16.00
23.00	02300	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	67,685	453,516	18,024	10,670	168,913	30.00
31.00	03100	9,989	66,927	773	1,575	2,147	31.00
41.00	04100	24,388	163,411	8,204	3,845	75,591	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	16,873	113,053	0	2,660	0	50.00
51.00	05100	10,153	68,032	0	1,601	883	51.00
53.00	05300	313	2,100	0	49	0	53.00
54.00	05400	17,732	118,811	0	2,795	0	54.00
54.01	03650	1,303	8,728	0	205	1,621	54.01
55.00	05500	25,245	169,153	0	3,980	2,023	55.00
57.00	05700	1,315	8,810	0	207	0	57.00
58.00	05800	1,494	10,013	0	236	0	58.00
59.00	05900	3,637	24,367	0	573	0	59.00
60.00	06000	5,569	37,316	0	878	0	60.00
62.00	06200	899	6,026	0	142	0	62.00
65.00	06500	1,291	8,651	0	204	0	65.00
66.00	06600	0	0	0	0	0	66.00
67.00	06700	7,111	47,646	0	1,121	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	6,391	42,823	0	1,008	0	69.00
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	495	3,319	0	78	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	2,128	14,256	0	335	10,886	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	631	4,227	0	99	0	76.97
76.98	07698	0	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	17,035	114,141	0	2,686	5,120	91.00
91.01	09101	0	0	0	0	0	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	0	0	0	0	0	91.03
91.04	09104	0	0	0	0	0	91.04
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		450,532	1,723,626	27,001	39,931	267,184	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,235	8,274	0	195	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
194.03	07953	468	3,139	0	74	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		452,235	1,735,039	27,001	40,200	267,184	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet B Part II Date/Time Prepared: 11/28/2018 10:09 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,467					11.00
13.00	01300	81	31,641				13.00
14.00	01400	28	1	182,513			14.00
15.00	01500	62	0	0	311,973		15.00
16.00	01600	13	12	0	0	94,889	16.00
23.00	02300	17	1	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	441	14,385	0	0	11,611	30.00
31.00	03100	77	2,805	0	0	2,293	31.00
41.00	04100	168	6,145	0	0	4,364	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	76	1,278	0	0	10,683	50.00
51.00	05100	78	2,616	0	0	4,235	51.00
53.00	05300	3	1	0	0	2,015	53.00
54.00	05400	90	413	0	0	3,295	54.00
54.01	03650	13	0	0	0	1,417	54.01
55.00	05500	36	487	0	0	1,743	55.00
57.00	05700	18	0	0	0	5,138	57.00
58.00	05800	7	0	0	0	1,456	58.00
59.00	05900	35	413	0	0	5,171	59.00
60.00	06000	3	0	0	0	6,251	60.00
62.00	06200	0	0	0	0	172	62.00
65.00	06500	41	0	0	0	1,476	65.00
66.00	06600	3	0	0	0	3,089	66.00
67.00	06700	0	0	0	0	1,289	67.00
68.00	06800	0	0	0	0	272	68.00
69.00	06900	25	93	0	0	2,993	69.00
71.00	07100	0	0	108,480	0	3,339	71.00
72.00	07200	0	0	74,033	0	7,163	72.00
73.00	07300	9	312	0	311,973	6,799	73.00
74.00	07400	0	0	0	0	305	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	15	82	0	0	951	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	8	117	0	0	176	76.97
76.98	07698	3	0	0	0	925	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	99	2,478	0	0	6,139	91.00
91.01	09101	2	0	0	0	88	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	13	0	0	0	41	91.03
91.04	09104	0	0	0	0	0	91.04
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,464	31,639	182,513	311,973	94,889	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	3	2	0	0	0	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,467	31,641	182,513	311,973	94,889	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet B Part II Date/Time Prepared: 11/28/2018 10:09 am
Cost Center	Description	PARAMED PRGM-AMBULANCE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	01160	COMMUNICATIONS				5.01
5.02	00560	PURCHASING RECEIVING AND STORES				5.02
5.03	00570	ADMINISTRATIVE				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.04
5.05	00590	OTHER ADMIN AND GENERAL				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
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
23.00	02300	PARAMED PRGM-AMBULANCE	2,618			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,323,619	0	1,323,619	30.00
31.00	03100	INTENSIVE CARE UNIT	176,713	0	176,713	31.00
41.00	04100	SUBPROVIDER - IRF	505,753	0	505,753	41.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	313,284	0	313,284	50.00
51.00	05100	RECOVERY ROOM	177,238	0	177,238	51.00
53.00	05300	ANESTHESIOLOGY	7,923	0	7,923	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,207	0	296,207	54.00
54.01	03650	VASCULAR LAB	25,125	0	25,125	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	412,616	0	412,616	55.00
57.00	05700	CT SCAN	28,385	0	28,385	57.00
58.00	05800	MRI	26,797	0	26,797	58.00
59.00	05900	CARDIAC CATHETERIZATION	89,479	0	89,479	59.00
60.00	06000	LABORATORY	110,969	0	110,969	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,455	0	14,455	62.00
65.00	06500	RESPIRATORY THERAPY	33,335	0	33,335	65.00
66.00	06600	PHYSICAL THERAPY	47,939	0	47,939	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,653	0	113,653	67.00
68.00	06800	SPEECH PATHOLOGY	409	0	409	68.00
69.00	06900	ELECTROCARDIOLOGY	109,326	0	109,326	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,376	0	139,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,917	0	100,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,601	0	340,601	73.00
74.00	07400	RENAL DIALYSIS	9,414	0	9,414	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	48,660	0	48,660	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	43,435	0	43,435	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	39,260	0	39,260	76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	90.01
91.00	09100	EMERGENCY	306,307	0	306,307	91.00
91.01	09101	CVILLE OUT	36,226	0	36,226	91.01
91.02	09102	LAKE HILL OUT	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1,314	0	1,314	91.03
91.04	09104	HUNTLEY OP	687	0	687	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,879,422	0	4,879,422
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19,620	0	19,620	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	194.00
194.01	07951	MOB	5,335	0	5,335	194.01
194.02	07952	COMMUNITY WELLNESS	1,295	0	1,295	194.02
194.03	07953	FUND DEVELOPMENT	7,710	0	7,710	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	2	0	2	194.04
200.00		Cross Foot Adjustments	2,618	0	2,618	200.00
201.00		Negative Cost Centers	0	7,142	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,618	4,923,144	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHONES)	PURCHASING RECEIVING AND STORES (PURCH REQUIS \$)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	669,374				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		669,374			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	911	911	19,672,387		4.00
5.01 01160	COMMUNICATIONS	5,513	5,513	64,644	576	5.01
5.02 00560	PURCHASING RECEIVING AND STORES	5,165	5,165	0	9	497,171
5.03 00570	ADMITTING	792	792	0	16	0
5.04 00580	CASHIERING/ACCOUNTS RECEIVABLE	0	0	0	21	0
5.05 00590	OTHER ADMIN AND GENERAL	33,274	33,274	980,448	90	324
6.00 00600	MAINTENANCE & REPAIRS	69,599	69,599	0	1	74
7.00 00700	OPERATION OF PLANT	236,834	236,834	670,281	20	30,084
8.00 00800	LAUNDRY & LINEN SERVICE	2,072	2,072	0	1	0
9.00 00900	HOUSEKEEPING	2,767	2,767	553,502	2	3,462
10.00 01000	DIETARY	19,859	19,859	464,406	13	6,053
11.00 01100	CAFETERIA	0	0	0	2	0
13.00 01300	NURSING ADMINISTRATION	1,654	1,654	1,120,523	21	5,087
14.00 01400	CENTRAL SERVICES & SUPPLY	7,718	7,718	197,289	5	16,286
15.00 01500	PHARMACY	2,630	2,630	924,595	7	10,515
16.00 01600	MEDICAL RECORDS & LIBRARY	6,878	6,878	187,752	20	492
23.00 02300	PARAMED ED PRGM-AMBULANCE	0	0	100,672	5	7,360
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	82,934	82,934	4,706,187	85	63,011
31.00 03100	INTENSIVE CARE UNIT	12,239	12,239	993,282	7	15,826
41.00 04100	SUBPROVIDER - I/R	29,883	29,883	1,775,409	13	34,333
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	20,674	20,674	948,434	31	64,226
51.00 05100	RECOVERY ROOM	12,441	12,441	921,386	6	9,101
53.00 05300	ANESTHESIOLOGY	384	384	36,009	3	1,343
54.00 05400	RADIOLOGY-DIAGNOSTIC	21,727	21,727	1,070,566	35	7,488
54.01 03650	VASCULAR LAB	1,596	1,596	193,535	1	2,023
55.00 05500	RADIOLOGY-THERAPEUTIC	30,933	30,933	452,027	31	3,995
57.00 05700	CT SCAN	1,611	1,611	197,082	0	2,069
58.00 05800	MRI	1,831	1,831	100,802	0	359
59.00 05900	CARDIAC CATHETERIZATION	4,456	4,456	530,676	0	132,717
60.00 06000	LABORATORY	6,824	6,824	46,743	20	9,874
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,102	1,102	0	1	7
65.00 06500	RESPIRATORY THERAPY	1,582	1,582	471,114	7	1,221
66.00 06600	PHYSICAL THERAPY	0	0	1,384	9	5,489
67.00 06700	OCCUPATIONAL THERAPY	8,713	8,713	0	1	156
68.00 06800	SPEECH PATHOLOGY	0	0	0	1	45
69.00 06900	ELECTROCARDIOLOGY	7,831	7,831	278,212	7	2,416
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	607	607	0	0	0
76.00 03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0
76.02 03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,607	2,607	161,110	17	0
76.03 03951	OCCUPATIONAL HEALTH	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	773	773	96,234	0	622
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	42,401	0	22,375
OUTPATIENT SERVICE COST CENTERS						
90.01 09001	OUTPATIENT PROCEDURES	0	0	0	0	0
91.00 09100	EMERGENCY	20,873	20,873	1,190,233	32	22,724
91.01 09101	CIVIL OUT	0	0	11,703	1	15,714
91.02 09102	LAKE HILL OUT	0	0	0	0	0
91.03 09103	NUTRITION COUNSELING	0	0	134,975	0	300
91.04 09104	HUNTLEY OP	0	0	0	0	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	667,287	667,287	19,623,616	541	497,171
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,513	1,513	0	2	0
194.00 07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0
194.01 07951	MOB	0	0	0	29	0
194.02 07952	COMMUNITY WELLNESS	0	0	48,771	0	0
194.03 07953	FUND DEVELOPMENT	574	574	0	4	0
194.04 07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0
200.00	Cross Foot Adjustments					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNICATIONS (NUMBER PHONES)	PURCHASING RECEIVING AND STORES (PURCH REQUIS \$)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					4.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)						202.00
203.00	2,311,526	1,982,364	-39,242	203,184	65,306	203.00	
204.00	Unit cost multiplier (Wkst. B, Part I)						204.00
205.00	3.453265	2.961519	0.000000	352.750000	0.131355	205.00	
206.00	Cost to be allocated (per Wkst. B, Part II)						206.00
207.00	Unit cost multiplier (Wkst. B, Part II)						207.00
208.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						208.00
209.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						209.00
			7,142	46,698	33,862		
			0.000363	81.072917	0.068109		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description			ADMINISTRATIVE (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160	COMMUNICATIONS						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMINISTRATIVE	439,366,136					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE		439,366,136				5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL			-20,116,111	54,909,440		5.05
6.00	00600	MAINTENANCE & REPAIRS				1,234,840	554,120	6.00
7.00	00700	OPERATION OF PLANT				3,807,750	236,834	7.00
8.00	00800	LAUNDRY & LINEN SERVICE				132,121	2,072	8.00
9.00	00900	HOUSEKEEPING				866,760	2,767	9.00
10.00	01000	DIETARY				915,142	19,859	10.00
11.00	01100	CAFETERIA				283,481		11.00
13.00	01300	NURSING ADMINISTRATION				1,552,584	1,654	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				376,432	7,718	14.00
15.00	01500	PHARMACY				1,461,604	2,630	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				1,030,686	6,878	16.00
23.00	02300	PARAMEDICAL PRGM-AMBULANCE				154,597		23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	53,816,479	53,816,479		6,575,167	82,934	30.00
31.00	03100	INTENSIVE CARE UNIT	10,614,105	10,614,105		1,589,692	12,239	31.00
41.00	04100	SUBPROVIDER - IRF	20,205,810	20,205,810		4,147,973	29,883	41.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	49,457,225	49,457,225		1,936,879	20,674	50.00
51.00	05100	RECOVERY ROOM	19,606,616	19,606,616		1,313,074	12,441	51.00
53.00	05300	ANESTHESIOLOGY	9,327,912	9,327,912		100,862	384	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,253,597	15,253,597		1,624,721	21,727	54.00
54.01	03650	VASCULAR LAB	6,560,568	6,560,568		272,894	1,596	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	8,067,893	8,067,893		1,229,765	30,933	55.00
57.00	05700	CT SCAN	23,787,596	23,787,596		397,752	1,611	57.00
58.00	05800	MRI	6,742,481	6,742,481		227,070	1,831	58.00
59.00	05900	CARDIAC CATHETERIZATION	23,938,342	23,938,342		866,944	4,456	59.00
60.00	06000	LABORATORY	28,940,835	28,940,835		2,599,000	6,824	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	796,994	796,994		11,095	1,102	62.00
65.00	06500	RESPIRATORY THERAPY	6,834,822	6,834,822		645,291	1,582	65.00
66.00	06600	PHYSICAL THERAPY	14,302,718	14,302,718		1,017,560		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,967,553	5,967,553		84,359	8,713	67.00
68.00	06800	SPEECH PATHOLOGY	1,261,186	1,261,186		6,317		68.00
69.00	06900	ELECTROCARDIOLOGY	13,856,395	13,856,395		478,606	7,831	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,459,653	15,459,653		5,920,218		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,162,762	33,162,762		4,145,762		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,475,104	31,475,104		4,540,721		73.00
74.00	07400	RENAL DIALYSIS	1,411,568	1,411,568		281,326	607	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER						76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4,401,449	4,401,449		249,436	2,607	76.02
76.03	03951	OCCUPATIONAL HEALTH						76.03
76.97	07697	CARDIAC REHABILITATION	813,686	813,686		158,806	773	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	4,283,244	4,283,244		458,383		76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES						90.01
91.00	09100	EMERGENCY	28,421,022	28,421,022		1,805,313	20,873	91.00
91.01	09101	CIVILLE OUT	407,310	407,310		128,916		91.01
91.02	09102	LAKE HILL OUT						91.02
91.03	09103	NUTRITION COUNSELING	191,211	191,211		163,688		91.03
91.04	09104	HUNTLEY OP				684		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	439,366,136	439,366,136	-20,116,111	54,794,271	552,033	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				10,412	1,513	190.00
194.00	07950	MISC NONREIMBURSABLE COST CENTER						194.00
194.01	07951	MOB				40,686		194.01
194.02	07952	COMMUNITY WELLNESS				58,488		194.02
194.03	07953	FUND DEVELOPMENT				5,093	574	194.03
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT				490		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMIN AND GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		5.03	5.04	5A.05	5.05	6.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	10,725	2,039,616		20,116,111	1,687,225	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000024	0.004642		0.366351	3.044873	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	6,378	1,703		252,874	452,235	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000015	0.000004		0.004605	0.816132	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: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	01160	COMMUNICATIONS					5.01
5.02	00560	PURCHASING RECEIVING AND STORES					5.02
5.03	00570	ADMITTING					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.04
5.05	00590	OTHER ADMIN AND GENERAL					5.05
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT	317,286				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,072	19,281			8.00
9.00	00900	HOUSEKEEPING	2,767	0	312,447		9.00
10.00	01000	DIETARY	19,859	0	19,859	51,764	10.00
11.00	01100	CAFETERIA	0	0	0	465,839	11.00
13.00	01300	NURSING ADMINISTRATION	1,654	0	1,654	0	25,835
14.00	01400	CENTRAL SERVICES & SUPPLY	7,718	0	7,718	0	8,984
15.00	01500	PHARMACY	2,630	0	2,630	0	19,737
16.00	01600	MEDICAL RECORDS & LIBRARY	6,878	0	6,878	0	4,052
23.00	02300	PARAMED PRGM-AMBULANCE	0	0	0	0	5,489
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	82,934	12,871	82,934	32,725	138,874
31.00	03100	INTENSIVE CARE UNIT	12,239	552	12,239	416	24,574
41.00	04100	SUBPROVIDER - IRF	29,883	5,858	29,883	14,645	53,377
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,674	0	20,674	0	24,201
51.00	05100	RECOVERY ROOM	12,441	0	12,441	171	24,922
53.00	05300	ANESTHESIOLOGY	384	0	384	0	861
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,727	0	21,727	0	28,574
54.01	03650	VASCULAR LAB	1,596	0	1,596	314	3,985
55.00	05500	RADIOLOGY-THERAPEUTIC	30,933	0	30,933	392	11,541
57.00	05700	CT SCAN	1,611	0	1,611	0	5,826
58.00	05800	MRI	1,831	0	1,831	0	2,068
59.00	05900	CARDIAC CATHETERIZATION	4,456	0	4,456	0	11,195
60.00	06000	LABORATORY	6,824	0	6,824	0	1,092
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,102	0	1,102	0	0
65.00	06500	RESPIRATORY THERAPY	1,582	0	1,582	0	13,003
66.00	06600	PHYSICAL THERAPY	0	0	0	0	909
67.00	06700	OCCUPATIONAL THERAPY	8,713	0	8,713	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	7,831	0	7,831	0	8,037
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	3,008
74.00	07400	RENAL DIALYSIS	607	0	607	0	0
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,607	0	2,607	2,109	4,833
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	773	0	773	0	2,615
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	1,082
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0
91.00	09100	EMERGENCY	20,873	0	20,873	992	31,312
91.01	09101	CIVILLE OUT	0	0	0	0	741
91.02	09102	LAKE HILL OUT	0	0	0	0	0
91.03	09103	NUTRITION COUNSELING	0	0	0	0	4,056
91.04	09104	HUNTLEY OP	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	315,199	19,281	310,360	51,764	464,783
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,513	0	1,513	0	0
194.00	07950	MISC NONREIMBURSABLE COST CENTER	0	0	0	0	0
194.01	07951	MOB	0	0	0	0	0
194.02	07952	COMMUNITY WELLNESS	0	0	0	0	1,056
194.03	07953	FUND DEVELOPMENT	574	0	574	0	0
194.04	07954	PHYSICIAN PRACTICE MANAGEMENT	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)	5,923,854	225,518	1,244,384	1,760,741	387,335

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	18.670392	11.696385	3.982704	34.014779	0.831478	203.00
204.00	Cost to be allocated (per Wkst. B, Part I)	1,735,039	27,001	40,200	267,184	1,467	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5.468376	1.400394	0.128662	5.161579	0.003149	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: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	PARAMED PRGM-AMBULANCE (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	01160						5.01
5.02	00560						5.02
5.03	00570						5.03
5.04	00580						5.04
5.05	00590						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	249,553					13.00
14.00	01400	6	9,839,104				14.00
15.00	01500	0	0	4,263,171			15.00
16.00	01600	95	0	0	439,366,136		16.00
23.00	02300	9	0	0	0	804	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	113,465	0	0	53,816,479	36	30.00
31.00	03100	22,121	0	0	10,614,105	84	31.00
41.00	04100	48,462	0	0	20,205,810	0	41.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	10,077	0	0	49,457,225	0	50.00
51.00	05100	20,632	0	0	19,606,616	0	51.00
53.00	05300	9	0	0	9,327,912	60	53.00
54.00	05400	3,258	0	0	15,253,597	0	54.00
54.01	03650	0	0	0	6,560,568	0	54.01
55.00	05500	3,844	0	0	8,067,893	0	55.00
57.00	05700	0	0	0	23,787,596	0	57.00
58.00	05800	0	0	0	6,742,481	0	58.00
59.00	05900	3,255	0	0	23,938,342	0	59.00
60.00	06000	0	0	0	28,940,835	0	60.00
62.00	06200	0	0	0	796,994	0	62.00
65.00	06500	0	0	0	6,834,822	0	65.00
66.00	06600	0	0	0	14,302,718	0	66.00
67.00	06700	0	0	0	5,967,553	0	67.00
68.00	06800	0	0	0	1,261,186	0	68.00
69.00	06900	735	0	0	13,856,395	0	69.00
71.00	07100	0	5,848,082	0	15,459,653	0	71.00
72.00	07200	0	3,991,022	0	33,162,762	0	72.00
73.00	07300	2,458	0	4,263,171	31,475,104	0	73.00
74.00	07400	0	0	0	1,411,568	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.02	03550	648	0	0	4,401,449	0	76.02
76.03	03951	0	0	0	0	0	76.03
76.97	07697	922	0	0	813,686	0	76.97
76.98	07698	0	0	0	4,283,244	0	76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	0	0	0	0	0	90.01
91.00	09100	19,544	0	0	28,421,022	600	91.00
91.01	09101	0	0	0	407,310	0	91.01
91.02	09102	0	0	0	0	0	91.02
91.03	09103	0	0	0	191,211	0	91.03
91.04	09104	0	0	0	0	0	91.04
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		249,540	9,839,104	4,263,171	439,366,136	780	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
194.02	07952	13	0	0	0	24	194.02
194.03	07953	0	0	0	0	0	194.03
194.04	07954	0	0	0	0	0	194.04
200.00							200.00
201.00							201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0217

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

Worksheet B-1

Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHAR GES)	PARAMED ED PRGM-AMBULANCE (ASSIGNED TIME)	
		13.00	14.00	15.00	16.00	23.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2,185,360	720,198	2,081,061	1,589,231	215,877	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.757098	0.073198	0.488149	0.003617	268.503731	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	31,641	182,513	311,973	94,889	2,618	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.126791	0.018550	0.073179	0.000216	3.256219	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: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 10:09 am
			Title XVIII	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Diallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		13,692,336	11,311	13,703,647
31.00	03100 INTENSIVE CARE UNIT		2,782,294	0	2,782,294
41.00	04100 SUBPROVIDER - I RF		7,544,034	0	7,544,034
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		3,464,992	0	3,464,992
51.00	05100 RECOVERY ROOM		2,391,960	0	2,391,960
53.00	05300 ANESTHESIOLOGY		198,324	0	198,324
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,885,741	5,511	2,891,252
54.01	03650 VASCULAR LAB		451,607	0	451,607
55.00	05500 RADIOLOGY-THERAPEUTIC		2,560,980	386	2,561,366
57.00	05700 CT SCAN		675,752	0	675,752
58.00	05800 MRI		383,416	0	383,416
59.00	05900 CARDIAC CATHETERIZATION		1,423,457	0	1,423,457
60.00	06000 LABORATORY		3,832,096	12,618	3,844,714
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		46,362	0	46,362
65.00	06500 RESPIRATORY THERAPY	0	957,883	0	957,883
66.00	06600 PHYSICAL THERAPY	0	1,442,833	0	1,442,833
67.00	06700 OCCUPATIONAL THERAPY	0	360,755	0	360,755
68.00	06800 SPEECH PATHOLOGY	0	13,193	0	13,193
69.00	06900 ELECTROCARDIOLOGY		918,423	0	918,423
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		8,573,077	0	8,573,077
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,076,651	0	6,076,651
73.00	07300 DRUGS CHARGED TO PATIENTS		8,423,151	0	8,423,151
74.00	07400 RENAL DIALYSIS		405,095	0	405,095
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE		0	0	0
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		505,163	0	505,163
76.03	03951 OCCUPATIONAL HEALTH		0	0	0
76.97	07697 CARDIAC REHABILITATION		250,041	0	250,041
76.98	07698 HYPERBARIC OXYGEN THERAPY		642,704	0	642,704
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 OUTPATIENT PROCEDURES		0	0	0
91.00	09100 EMERGENCY		3,497,914	2,035	3,499,949
91.01	09101 CIVILLE OUT		178,234	0	178,234
91.02	09102 LAKE HILL OUT		0	0	0
91.03	09103 NUTRITION COUNSELING		227,719	0	227,719
91.04	09104 HUNTLEY OP		935	0	935
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,293,032	0	1,293,032
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		76,100,154	31,861	76,132,015
201.00	Less Observation Beds		1,293,032		1,293,032
202.00	Total (see instructions)		74,807,122	31,861	74,838,983

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet C Part I Date/Time Prepared: 11/28/2018 10:09 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	48,663,621		48,663,621				30.00
31.00	03100	INTENSIVE CARE UNIT	10,614,105		10,614,105				31.00
41.00	04100	SUBPROVIDER - IRF	20,205,810		20,205,810				41.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	29,910,516	19,546,709	49,457,225	0.070060	0.000000		50.00
51.00	05100	RECOVERY ROOM	10,046,584	9,560,032	19,606,616	0.121998	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	4,857,184	4,470,728	9,327,912	0.021261	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,257,569	10,996,028	15,253,597	0.189184	0.000000		54.00
54.01	03650	VASCULAR LAB	1,576,252	4,984,316	6,560,568	0.068837	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	225,744	7,842,149	8,067,893	0.317429	0.000000		55.00
57.00	05700	CT SCAN	6,091,809	17,695,787	23,787,596	0.028408	0.000000		57.00
58.00	05800	MRI	1,676,828	5,065,653	6,742,481	0.056866	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	9,345,700	14,592,642	23,938,342	0.059463	0.000000		59.00
60.00	06000	LABORATORY	14,641,938	14,298,898	28,940,836	0.132411	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	548,203	248,791	796,994	0.058171	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	6,095,049	739,774	6,834,823	0.140147	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	8,720,641	5,582,077	14,302,718	0.100878	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,925,185	42,368	5,967,553	0.060453	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,220,607	40,579	1,261,186	0.010461	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	4,543,414	9,312,981	13,856,395	0.066282	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,367,887	8,091,766	15,459,653	0.554545	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,921,853	5,240,910	33,162,763	0.183237	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,607,933	17,867,171	31,475,104	0.267613	0.000000		73.00
74.00	07400	RENAL DIALYSIS	1,323,343	88,225	1,411,568	0.286982	0.000000		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0.000000	0.000000		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,439,179	962,270	4,401,449	0.114772	0.000000		76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	553	813,133	813,686	0.307294	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	16,593	4,266,651	4,283,244	0.150051	0.000000		76.98
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	0.000000		90.01
91.00	09100	EMERGENCY	8,789,032	19,631,990	28,421,022	0.123075	0.000000		91.00
91.01	09101	C'VILLE OUT	879	406,431	407,310	0.437588	0.000000		91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	0.000000		91.02
91.03	09103	NUTRITION COUNSELING	0	191,211	191,211	1.190930	0.000000		91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	0.000000		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,745,174	3,407,684	5,152,858	0.250935	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	253,379,185	185,986,954	439,366,139				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	253,379,185	185,986,954	439,366,139				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 10:09 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital
		11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.070060		50.00
51.00	05100 RECOVERY ROOM	0.121998		51.00
53.00	05300 ANESTHESIOLOGY	0.021261		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.189546		54.00
54.01	03650 VASCULAR LAB	0.068837		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.317476		55.00
57.00	05700 CT SCAN	0.028408		57.00
58.00	05800 MRI	0.056866		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.059463		59.00
60.00	06000 LABORATORY	0.132847		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.058171		62.00
65.00	06500 RESPIRATORY THERAPY	0.140147		65.00
66.00	06600 PHYSICAL THERAPY	0.100878		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.060453		67.00
68.00	06800 SPEECH PATHOLOGY	0.010461		68.00
69.00	06900 ELECTROCARDIOLOGY	0.066282		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.554545		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.183237		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.267613		73.00
74.00	07400 RENAL DIALYSIS	0.286982		74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000		76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.114772		76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000		76.03
76.97	07697 CARDIAC REHABILITATION	0.307294		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.150051		76.98
OUTPATIENT SERVICE COST CENTERS				
90.01	09001 OUTPATIENT PROCEDURES	0.000000		90.01
91.00	09100 EMERGENCY	0.123146		91.00
91.01	09101 CIVILLE OUT	0.437588		91.01
91.02	09102 LAKE HILL OUT	0.000000		91.02
91.03	09103 NUTRITION COUNSELING	1.190930		91.03
91.04	09104 HUNTLEY OP	0.000000		91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.250935		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 10:09 am
			Title XIX	Hospital	PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
			Total Costs	RCE Diallowance	Total Costs
	1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		13,692,336	11,311	13,703,647
31.00	03100 INTENSIVE CARE UNIT		2,782,294	0	2,782,294
41.00	04100 SUBPROVIDER - I RF		7,544,034	0	7,544,034
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		3,464,992	0	3,464,992
51.00	05100 RECOVERY ROOM		2,391,960	0	2,391,960
53.00	05300 ANESTHESIOLOGY		198,324	0	198,324
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,885,741	5,511	2,891,252
54.01	03650 VASCULAR LAB		451,607	0	451,607
55.00	05500 RADIOLOGY-THERAPEUTIC		2,560,980	386	2,561,366
57.00	05700 CT SCAN		675,752	0	675,752
58.00	05800 MRI		383,416	0	383,416
59.00	05900 CARDIAC CATHETERIZATION		1,423,457	0	1,423,457
60.00	06000 LABORATORY		3,832,096	12,618	3,844,714
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		46,362	0	46,362
65.00	06500 RESPIRATORY THERAPY	0	957,883	0	957,883
66.00	06600 PHYSICAL THERAPY	0	1,442,833	0	1,442,833
67.00	06700 OCCUPATIONAL THERAPY	0	360,755	0	360,755
68.00	06800 SPEECH PATHOLOGY	0	13,193	0	13,193
69.00	06900 ELECTROCARDIOLOGY		918,423	0	918,423
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		8,573,077	0	8,573,077
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		6,076,651	0	6,076,651
73.00	07300 DRUGS CHARGED TO PATIENTS		8,423,151	0	8,423,151
74.00	07400 RENAL DIALYSIS		405,095	0	405,095
76.00	03950 OTHER ANCILLARY SERVICES COST CENTE		0	0	0
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		505,163	0	505,163
76.03	03951 OCCUPATIONAL HEALTH		0	0	0
76.97	07697 CARDIAC REHABILITATION		250,041	0	250,041
76.98	07698 HYPERBARIC OXYGEN THERAPY		642,704	0	642,704
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 OUTPATIENT PROCEDURES		0	0	0
91.00	09100 EMERGENCY		3,497,914	2,035	3,499,949
91.01	09101 CIVILLE OUT		178,234	0	178,234
91.02	09102 LAKE HILL OUT		0	0	0
91.03	09103 NUTRITION COUNSELING		227,719	0	227,719
91.04	09104 HUNTLEY OP		935	0	935
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1,293,032	0	1,293,032
SPECIAL PURPOSE COST CENTERS					
113.00	11300 INTEREST EXPENSE				
200.00	Subtotal (see instructions)		76,100,154	31,861	76,132,015
201.00	Less Observation Beds		1,293,032		1,293,032
202.00	Total (see instructions)		74,807,122	31,861	74,838,983

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet C Part I Date/Time Prepared: 11/28/2018 10:09 am		
			Title XIX			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	48,663,621		48,663,621				30.00
31.00	03100	INTENSIVE CARE UNIT	10,614,105		10,614,105				31.00
41.00	04100	SUBPROVIDER - IRF	20,205,810		20,205,810				41.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	29,910,516	19,546,709	49,457,225	0.070060	0.000000		50.00
51.00	05100	RECOVERY ROOM	10,046,584	9,560,032	19,606,616	0.121998	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	4,857,184	4,470,728	9,327,912	0.021261	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,257,569	10,996,028	15,253,597	0.189184	0.000000		54.00
54.01	03650	VASCULAR LAB	1,576,252	4,984,316	6,560,568	0.068837	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	225,744	7,842,149	8,067,893	0.317429	0.000000		55.00
57.00	05700	CT SCAN	6,091,809	17,695,787	23,787,596	0.028408	0.000000		57.00
58.00	05800	MRI	1,676,828	5,065,653	6,742,481	0.056866	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	9,345,700	14,592,642	23,938,342	0.059463	0.000000		59.00
60.00	06000	LABORATORY	14,641,938	14,298,898	28,940,836	0.132411	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	548,203	248,791	796,994	0.058171	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	6,095,049	739,774	6,834,823	0.140147	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	8,720,641	5,582,077	14,302,718	0.100878	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,925,185	42,368	5,967,553	0.060453	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,220,607	40,579	1,261,186	0.010461	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	4,543,414	9,312,981	13,856,395	0.066282	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,367,887	8,091,766	15,459,653	0.554545	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,921,853	5,240,910	33,162,763	0.183237	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,607,933	17,867,171	31,475,104	0.267613	0.000000		73.00
74.00	07400	RENAL DIALYSIS	1,323,343	88,225	1,411,568	0.286982	0.000000		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0.000000	0.000000		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,439,179	962,270	4,401,449	0.114772	0.000000		76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0.000000	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	553	813,133	813,686	0.307294	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	16,593	4,266,651	4,283,244	0.150051	0.000000		76.98
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0.000000	0.000000		90.01
91.00	09100	EMERGENCY	8,789,032	19,631,990	28,421,022	0.123075	0.000000		91.00
91.01	09101	CVILLE OUT	879	406,431	407,310	0.437588	0.000000		91.01
91.02	09102	LAKE HILL OUT	0	0	0	0.000000	0.000000		91.02
91.03	09103	NUTRITION COUNSELING	0	191,211	191,211	1.190930	0.000000		91.03
91.04	09104	HUNTLEY OP	0	0	0	0.000000	0.000000		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,745,174	3,407,684	5,152,858	0.250935	0.000000		92.00
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	253,379,185	185,986,954	439,366,139				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	253,379,185	185,986,954	439,366,139				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part I Date/Time Prepared: 11/28/2018 10:09 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.070060		50.00
51.00	05100	RECOVERY ROOM	0.121998		51.00
53.00	05300	ANESTHESIOLOGY	0.021261		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189546		54.00
54.01	03650	VASCULAR LAB	0.068837		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317476		55.00
57.00	05700	CT SCAN	0.028408		57.00
58.00	05800	MRI	0.056866		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059463		59.00
60.00	06000	LABORATORY	0.132847		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.058171		62.00
65.00	06500	RESPIRATORY THERAPY	0.140147		65.00
66.00	06600	PHYSICAL THERAPY	0.100878		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.060453		67.00
68.00	06800	SPEECH PATHOLOGY	0.010461		68.00
69.00	06900	ELECTROCARDIOLOGY	0.066282		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554545		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183237		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267613		73.00
74.00	07400	RENAL DIALYSIS	0.286982		74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0.000000		76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.114772		76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000		76.03
76.97	07697	CARDIAC REHABILITATION	0.307294		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.150051		76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0.000000		90.01
91.00	09100	EMERGENCY	0.123146		91.00
91.01	09101	CIVILLE OUT	0.437588		91.01
91.02	09102	LAKE HILL OUT	0.000000		91.02
91.03	09103	NUTRITION COUNSELING	1.190930		91.03
91.04	09104	HUNTLEY OP	0.000000		91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250935		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0217

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

Worksheet C Part II Date/Time Prepared: 11/28/2018 10:09 am

Cost Center Description		Title XIX			Hospital	PPS		
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,464,992	313,284	3,151,708	0	0	50.00
51.00	05100	RECOVERY ROOM	2,391,960	177,238	2,214,722	0	0	51.00
53.00	05300	ANESTHESIOLOGY	198,324	7,923	190,401	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,885,741	296,207	2,589,534	0	0	54.00
54.01	03650	VASCULAR LAB	451,607	25,125	426,482	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	2,560,980	412,616	2,148,364	0	0	55.00
57.00	05700	CT SCAN	675,752	28,385	647,367	0	0	57.00
58.00	05800	MRI	383,416	26,797	356,619	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,423,457	89,479	1,333,978	0	0	59.00
60.00	06000	LABORATORY	3,832,096	110,969	3,721,127	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	46,362	14,455	31,907	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	957,883	33,335	924,548	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,442,833	47,939	1,394,894	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	360,755	113,653	247,102	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,193	409	12,784	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	918,423	109,326	809,097	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,573,077	139,376	8,433,701	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,076,651	100,917	5,975,734	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,423,151	340,601	8,082,550	0	0	73.00
74.00	07400	RENAL DIALYSIS	405,095	9,414	395,681	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	505,163	48,660	456,503	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	250,041	43,435	206,606	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	642,704	39,260	603,444	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	3,497,914	306,307	3,191,607	0	0	91.00
91.01	09101	CVILLE OUT	178,234	36,226	142,008	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	227,719	1,314	226,405	0	0	91.03
91.04	09104	HUNTLEY OP	935	687	248	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,293,032	124,893	1,168,139	0	0	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	52,081,490	2,998,230	49,083,260	0	0	200.00
201.00		Less Observation Beds	1,293,032	124,893	1,168,139	0	0	201.00
202.00		Total (line 200 minus line 201)	50,788,458	2,873,337	47,915,121	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet C Part II Date/Time Prepared: 11/28/2018 10:09 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3,464,992	49,457,225	0.070060		50.00
51.00	05100 RECOVERY ROOM	2,391,960	19,606,616	0.121998		51.00
53.00	05300 ANESTHESIOLOGY	198,324	9,327,912	0.021261		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,885,741	15,253,597	0.189184		54.00
54.01	03650 VASCULAR LAB	451,607	6,560,568	0.068837		54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	2,560,980	8,067,893	0.317429		55.00
57.00	05700 CT SCAN	675,752	23,787,596	0.028408		57.00
58.00	05800 MRI	383,416	6,742,481	0.056866		58.00
59.00	05900 CARDIAC CATHETERIZATION	1,423,457	23,938,342	0.059463		59.00
60.00	06000 LABORATORY	3,832,096	28,940,836	0.132411		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	46,362	796,994	0.058171		62.00
65.00	06500 RESPIRATORY THERAPY	957,883	6,834,823	0.140147		65.00
66.00	06600 PHYSICAL THERAPY	1,442,833	14,302,718	0.100878		66.00
67.00	06700 OCCUPATIONAL THERAPY	360,755	5,967,553	0.060453		67.00
68.00	06800 SPEECH PATHOLOGY	13,193	1,261,186	0.010461		68.00
69.00	06900 ELECTROCARDIOLOGY	918,423	13,856,395	0.066282		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8,573,077	15,459,653	0.554545		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6,076,651	33,162,763	0.183237		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8,423,151	31,475,104	0.267613		73.00
74.00	07400 RENAL DIALYSIS	405,095	1,411,568	0.286982		74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000		76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	505,163	4,401,449	0.114772		76.02
76.03	03951 OCCUPATIONAL HEALTH	0	0	0.000000		76.03
76.97	07697 CARDIAC REHABILITATION	250,041	813,686	0.307294		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	642,704	4,283,244	0.150051		76.98
OUTPATIENT SERVICE COST CENTERS						
90.01	09001 OUTPATIENT PROCEDURES	0	0	0.000000		90.01
91.00	09100 EMERGENCY	3,497,914	28,421,022	0.123075		91.00
91.01	09101 CIVILLE OUT	178,234	407,310	0.437588		91.01
91.02	09102 LAKE HILL OUT	0	0	0.000000		91.02
91.03	09103 NUTRITION COUNSELING	227,719	191,211	1.190930		91.03
91.04	09104 HUNTLEY OP	935	0	0.000000		91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,293,032	5,152,858	0.250935		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	52,081,490	359,882,603			200.00
201.00	Less Observation Beds	1,293,032	0			201.00
202.00	Total (line 200 minus line 201)	50,788,458	359,882,603			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part I Date/Time Prepared: 11/28/2018 10:09 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
Title XVIII		Hospital PPS					
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	1,323,619	0	1,323,619	14,212	93.13	30.00
31.00	INTENSIVE CARE UNIT	176,713		176,713	552	320.13	31.00
41.00	SUBPROVIDER - IRF	505,753	0	505,753	5,858	86.34	41.00
200.00	Total (Lines 30 through 199)	2,006,085		2,006,085	20,622		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	4,973	463,135				
31.00	INTENSIVE CARE UNIT	545	174,471				
41.00	SUBPROVIDER - IRF	4,892	422,375				
200.00	Total (Lines 30 through 199)	10,410	1,059,981				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

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

Worksheet D
Part II
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital		Capital Costs (column 3 x column 4)	
					Inpatient Program Charges	PPS		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	313,284	49,457,225	0.006334	14,631,294	92,675	50.00
51.00	05100	RECOVERY ROOM	177,238	19,606,616	0.009040	4,963,742	44,872	51.00
53.00	05300	ANESTHESIOLOGY	7,923	9,327,912	0.000849	2,189,172	1,859	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,207	15,253,597	0.019419	2,226,969	43,246	54.00
54.01	03650	VASCULAR LAB	25,125	6,560,568	0.003830	682,622	2,614	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	412,616	8,067,893	0.051143	67,278	3,441	55.00
57.00	05700	CT SCAN	28,385	23,787,596	0.001193	2,895,963	3,455	57.00
58.00	05800	MRI	26,797	6,742,481	0.003974	829,855	3,298	58.00
59.00	05900	CARDIAC CATHETERIZATION	89,479	23,938,342	0.003738	4,200,059	15,700	59.00
60.00	06000	LABORATORY	110,969	28,940,836	0.003834	6,238,376	23,918	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,455	796,994	0.018137	259,626	4,709	62.00
65.00	06500	RESPIRATORY THERAPY	33,335	6,834,823	0.004877	2,682,831	13,084	65.00
66.00	06600	PHYSICAL THERAPY	47,939	14,302,718	0.003352	1,652,538	5,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,653	5,967,553	0.019045	692,498	13,189	67.00
68.00	06800	SPEECH PATHOLOGY	409	1,261,186	0.000324	347,150	112	68.00
69.00	06900	ELECTROCARDIOLOGY	109,326	13,856,395	0.007890	2,244,572	17,710	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,376	15,459,653	0.009015	3,430,272	30,924	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,917	33,162,763	0.003043	14,914,106	45,384	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,601	31,475,104	0.010821	5,468,503	59,175	73.00
74.00	07400	RENAL DIALYSIS	9,414	1,411,568	0.006669	530,318	3,537	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	48,660	4,401,449	0.011055	438,629	4,849	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	43,435	813,686	0.053381	553	30	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	39,260	4,283,244	0.009166	16,542	152	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	306,307	28,421,022	0.010777	3,567,808	38,450	91.00
91.01	09101	CIVILLE OUT	36,226	407,310	0.088940	875	78	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1,314	191,211	0.006872	0	0	91.03
91.04	09104	HUNTLEY OP	687	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	124,893	5,152,858	0.024238	800,804	19,410	92.00
200.00		Total (lines 50 through 199)	2,998,230	359,882,603		75,972,955	491,410	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/28/2018 10:09 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	9,666	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	22,554	0 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00	
200.00		Total (lines 30 through 199)	0	0	0	32,220	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	9,666	14,212	0.68	4,973 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	22,554	552	40.86	545 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	5,858	0.00	4,892 41.00	
200.00		Total (lines 30 through 199)	0	32,220	20,622	10,410	10,410 200.00	
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	3,382					30.00
31.00	03100	INTENSIVE CARE UNIT	22,269					31.00
41.00	04100	SUBPROVIDER - I RF	0					41.00
200.00		Total (lines 30 through 199)	25,651					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:09 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		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	16,110	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01 03650 VASCULAR LAB	0	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
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 03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	0	76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	0	76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS							
90.01 09001 OUTPATIENT PROCEDURES	0	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	0	0	161,103	91.00
91.01 09101 C'VILLE OUT	0	0	0	0	0	0	91.01
91.02 09102 LAKE HILL OUT	0	0	0	0	0	0	91.02
91.03 09103 NUTRITION COUNSELING	0	0	0	0	0	0	91.03
91.04 09104 HUNTLEY OP	0	0	0	0	0	0	91.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	912	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	0	178,125	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		Title XVIII		Hospital		PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	49,457,225	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	19,606,616	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	16,110	16,110	9,327,912	0.001727	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,253,597	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	6,560,568	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	8,067,893	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	23,787,596	0.000000	57.00
58.00	05800	MRI	0	0	0	6,742,481	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	23,938,342	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	28,940,836	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	796,994	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,834,823	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,302,718	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,967,553	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,261,186	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,856,395	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,459,653	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,162,763	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,475,104	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,411,568	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,401,449	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	813,686	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	4,283,244	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	161,103	161,103	28,421,022	0.005668	91.00
91.01	09101	CVILLE OUT	0	0	0	407,310	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	191,211	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	912	912	5,152,858	0.000177	92.00
200.00		Total (lines 50 through 199)	0	178,125	178,125	359,882,603		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:09 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			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	14,631,294	0	6,056,172	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	4,963,742	0	2,946,065	0	51.00	
53.00	05300	ANESTHESIOLOGY	0.001727	2,189,172	3,781	1,347,537	2,327	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,226,969	0	3,335,491	0	54.00	
54.01	03650	VASCULAR LAB	0.000000	682,622	0	1,199,858	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	67,278	0	3,172,262	0	55.00	
57.00	05700	CT SCAN	0.000000	2,895,963	0	4,370,312	0	57.00	
58.00	05800	MRI	0.000000	829,855	0	1,683,667	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	4,200,059	0	7,248,640	0	59.00	
60.00	06000	LABORATORY	0.000000	6,238,376	0	2,682,467	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	259,626	0	69,445	0	62.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	2,682,831	0	218,291	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.000000	1,652,538	0	67,654	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	692,498	0	9,696	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	347,150	0	3,868	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,244,572	0	3,784,361	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,430,272	0	3,679,939	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	14,914,106	0	2,289,301	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,468,503	0	5,777,902	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	530,318	0	31,779	0	74.00	
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0	76.00	
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	438,629	0	0	0	76.02	
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03	
76.97	07697	CARDIAC REHABILITATION	0.000000	553	0	336,256	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	16,542	0	1,716,355	0	76.98	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.005668	3,567,808	20,222	3,340,855	18,936	91.00	
91.01	09101	CVILLE OUT	0.000000	875	0	3,061	0	91.01	
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02	
91.03	09103	NUTRITION COUNSELING	0.000000	0	0	1,882	0	91.03	
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000177	800,804	142	1,223,245	217	92.00	
200.00		Total (lines 50 through 199)		75,972,955	24,145	56,596,361	21,480	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 10:09 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			
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.070060	6,056,172	0	249	424,295	50.00
51.00	05100	RECOVERY ROOM	0.121998	2,946,065	0	0	359,414	51.00
53.00	05300	ANESTHESIOLOGY	0.021261	1,347,537	0	0	28,650	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189184	3,335,491	0	0	631,022	54.00
54.01	03650	VASCULAR LAB	0.068837	1,199,858	0	0	82,595	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317429	3,172,262	0	0	1,006,968	55.00
57.00	05700	CT SCAN	0.028408	4,370,312	0	0	124,152	57.00
58.00	05800	MRI	0.056866	1,683,667	0	142	95,743	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059463	7,248,640	0	0	431,026	59.00
60.00	06000	LABORATORY	0.132411	2,682,467	0	0	355,188	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.058171	69,445	0	0	4,040	62.00
65.00	06500	RESPIRATORY THERAPY	0.140147	218,291	0	0	30,593	65.00
66.00	06600	PHYSICAL THERAPY	0.100878	67,654	0	0	6,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.060453	9,696	0	0	586	67.00
68.00	06800	SPEECH PATHOLOGY	0.010461	3,868	0	0	40	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066282	3,784,361	0	0	250,835	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554545	3,679,939	0	25	2,040,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183237	2,289,301	0	0	419,485	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267613	5,777,902	0	22,208	1,546,242	73.00
74.00	07400	RENAL DIALYSIS	0.286982	31,779	0	0	9,120	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.114772	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.307294	336,256	0	0	103,329	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.150051	1,716,355	0	839	257,541	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.123075	3,340,855	0	0	411,176	91.00
91.01	09101	CVILLE OUT	0.437588	3,061	0	0	1,339	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1.190930	1,882	0	0	2,241	91.03
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250935	1,223,245	0	0	306,955	92.00
200.00		Subtotal (see instructions)		56,596,361	0	23,463	8,930,092	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		56,596,361	0	23,463	8,930,092	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 10:09 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		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	17		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 03650 VASCULAR LAB	0	0		54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0		55.00
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MRI	0	8		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	14		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,943		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.00 03950 OTHER ANCILLARY SERVICES COST CENTE	0	0		76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0		76.03
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	126		76.98
OUTPATIENT SERVICE COST CENTERS				
90.01 09001 OUTPATIENT PROCEDURES	0	0		90.01
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 CIVILLE OUT	0	0		91.01
91.02 09102 LAKE HILL OUT	0	0		91.02
91.03 09103 NUTRITION COUNSELING	0	0		91.03
91.04 09104 HUNTLEY OP	0	0		91.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00 Subtotal (see instructions)	0	6,108		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	6,108		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 01/01/2018 To 06/30/2018		Worksheet D Part II Date/Time Prepared: 11/28/2018 10:09 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	313,284	49,457,225	0.006334	19,484	123	50.00
51.00	05100	RECOVERY ROOM	177,238	19,606,616	0.009040	5,494	50	51.00
53.00	05300	ANESTHESIOLOGY	7,923	9,327,912	0.000849	870	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,207	15,253,597	0.019419	192,385	3,736	54.00
54.01	03650	VASCULAR LAB	25,125	6,560,568	0.003830	92,369	354	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	412,616	8,067,893	0.051143	0	0	55.00
57.00	05700	CT SCAN	28,385	23,787,596	0.001193	163,967	196	57.00
58.00	05800	MRI	26,797	6,742,481	0.003974	50,513	201	58.00
59.00	05900	CARDIAC CATHETERIZATION	89,479	23,938,342	0.003738	4,066	15	59.00
60.00	06000	LABORATORY	110,969	28,940,836	0.003834	1,347,563	5,167	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,455	796,994	0.018137	4,204	76	62.00
65.00	06500	RESPIRATORY THERAPY	33,335	6,834,823	0.004877	850,066	4,146	65.00
66.00	06600	PHYSICAL THERAPY	47,939	14,302,718	0.003352	4,946,556	16,581	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,653	5,967,553	0.019045	3,959,885	75,416	67.00
68.00	06800	SPEECH PATHOLOGY	409	1,261,186	0.000324	588,410	191	68.00
69.00	06900	ELECTROCARDIOLOGY	109,326	13,856,395	0.007890	80,995	639	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,376	15,459,653	0.009015	8,061	73	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,917	33,162,763	0.003043	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,601	31,475,104	0.010821	1,533,088	16,590	73.00
74.00	07400	RENAL DIALYSIS	9,414	1,411,568	0.006669	313,271	2,089	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	48,660	4,401,449	0.011055	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	43,435	813,686	0.053381	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	39,260	4,283,244	0.009166	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	306,307	28,421,022	0.010777	12,510	135	91.00
91.01	09101	CVILLE OUT	36,226	407,310	0.088940	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1,314	191,211	0.006872	0	0	91.03
91.04	09104	HUNTLEY OP	687	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,152,858	0.000000	25,986	0	92.00
200.00		Total (lines 50 through 199)	2,873,337	359,882,603		14,199,743	125,779	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:09 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	16,110	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01 03650 VASCULAR LAB	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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 03950 OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0	76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS						
90.01 09001 OUTPATIENT PROCEDURES	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	0	161,103	91.00
91.01 09101 CIVILLE OUT	0	0	0	0	0	91.01
91.02 09102 LAKE HILL OUT	0	0	0	0	0	91.02
91.03 09103 NUTRITION COUNSELING	0	0	0	0	0	91.03
91.04 09104 HUNTLEY OP	0	0	0	0	0	91.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50 through 199)	0	0	0	0	177,213	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:09 am
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
		4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	49,457,225	0.000000 50.00
51.00	05100	RECOVERY ROOM	0	0	0	19,606,616	0.000000 51.00
53.00	05300	ANESTHESIOLOGY	0	16,110	16,110	9,327,912	0.001727 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,253,597	0.000000 54.00
54.01	03650	VASCULAR LAB	0	0	0	6,560,568	0.000000 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	8,067,893	0.000000 55.00
57.00	05700	CT SCAN	0	0	0	23,787,596	0.000000 57.00
58.00	05800	MRI	0	0	0	6,742,481	0.000000 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	23,938,342	0.000000 59.00
60.00	06000	LABORATORY	0	0	0	28,940,836	0.000000 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	796,994	0.000000 62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,834,823	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,302,718	0.000000 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,967,553	0.000000 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,261,186	0.000000 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,856,395	0.000000 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,459,653	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,162,763	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,475,104	0.000000 73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,411,568	0.000000 74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0.000000 76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,401,449	0.000000 76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000 76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	813,686	0.000000 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	4,283,244	0.000000 76.98
OUTPATIENT SERVICE COST CENTERS							
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000 90.01
91.00	09100	EMERGENCY	0	161,103	161,103	28,421,022	0.005668 91.00
91.01	09101	CVILLE OUT	0	0	0	407,310	0.000000 91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000 91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	191,211	0.000000 91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000 91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,152,858	0.000000 92.00
200.00		Total (lines 50 through 199)	0	177,213	177,213	359,882,603	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:09 am
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Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	19,484	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	5,494	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.001727	870	2	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	192,385	0	0	0	54.00
54.01	03650 VASCULAR LAB	0.000000	92,369	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	163,967	0	0	0	57.00
58.00	05800 MRI	0.000000	50,513	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	4,066	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	1,347,563	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	4,204	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	850,066	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	4,946,556	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	3,959,885	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	588,410	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	80,995	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	8,061	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	1,533,088	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	313,271	0	0	0	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.005668	12,510	71	1,076	6	91.00
91.01	09101 C'VILLE OUT	0.000000	0	0	0	0	91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	0	0	91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	25,986	0	0	0	92.00
200.00	Total (lines 50 through 199)		14,199,743	73	1,076	6	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
			1.00	2.00			3.00	4.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.070060	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.121998	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.021261	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189184	0	0	0	0	54.00
54.01	03650	VASCULAR LAB	0.068837	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317429	0	0	0	0	55.00
57.00	05700	CT SCAN	0.028408	0	0	0	0	57.00
58.00	05800	MRI	0.056866	0	0	1	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059463	0	0	0	0	59.00
60.00	06000	LABORATORY	0.132411	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.058171	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.140147	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.100878	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.060453	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.010461	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.066282	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554545	0	0	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183237	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267613	0	0	1,929	0	73.00
74.00	07400	RENAL DIALYSIS	0.286982	0	0	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.114772	0	0	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	0.307294	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.150051	0	0	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.123075	1,076	0	0	132	91.00
91.01	09101	CVILLE OUT	0.437588	0	0	0	0	91.01
91.02	09102	LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1.190930	0	0	0	0	91.03
91.04	09104	HUNTLEY OP	0.000000	0	0	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250935	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,076	0	1,931	132	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00		Net Charges (line 200 - line 201)		1,076	0	1,931	132	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part V Date/Time Prepared: 11/28/2018 10:09 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 03650 VASCULAR LAB	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	55.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	516	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0	76.03
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
OUTPATIENT SERVICE COST CENTERS			
90.01 09001 OUTPATIENT PROCEDURES	0	0	90.01
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 C'VILLE OUT	0	0	91.01
91.02 09102 LAKE HILL OUT	0	0	91.02
91.03 09103 NUTRITION COUNSELING	0	0	91.03
91.04 09104 HUNTLEY OP	0	0	91.04
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00 Subtotal (see instructions)	0	517	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	517	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part I Date/Time Prepared: 11/28/2018 10:09 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)	
		1.00	2.00	3.00	4.00	5.00	
Title XIX Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,323,619	0	1,323,619	14,212	93.13	30.00
31.00	INTENSIVE CARE UNIT	176,713		176,713	552	320.13	31.00
41.00	SUBPROVIDER - IRF	505,753	0	505,753	5,858	86.34	41.00
200.00	Total (Lines 30 through 199)	2,006,085		2,006,085	20,622		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	867	80,744				
31.00	INTENSIVE CARE UNIT	7	2,241				
41.00	SUBPROVIDER - IRF	0	0				
200.00	Total (Lines 30 through 199)	874	82,985				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0217

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

Worksheet D
Part II
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		Title XIX			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	313,284	49,457,225	0.006334	0	0	50.00
51.00	05100	RECOVERY ROOM	177,238	19,606,616	0.009040	0	0	51.00
53.00	05300	ANESTHESIOLOGY	7,923	9,327,912	0.000849	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,207	15,253,597	0.019419	0	0	54.00
54.01	03650	VASCULAR LAB	25,125	6,560,568	0.003830	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	412,616	8,067,893	0.051143	0	0	55.00
57.00	05700	CT SCAN	28,385	23,787,596	0.001193	0	0	57.00
58.00	05800	MRI	26,797	6,742,481	0.003974	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	89,479	23,938,342	0.003738	0	0	59.00
60.00	06000	LABORATORY	110,969	28,940,836	0.003834	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	14,455	796,994	0.018137	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	33,335	6,834,823	0.004877	0	0	65.00
66.00	06600	PHYSICAL THERAPY	47,939	14,302,718	0.003352	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	113,653	5,967,553	0.019045	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	409	1,261,186	0.000324	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	109,326	13,856,395	0.007890	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	139,376	15,459,653	0.009015	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,917	33,162,763	0.003043	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	340,601	31,475,104	0.010821	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,414	1,411,568	0.006669	0	0	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTER	0	0	0.000000	0	0	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	48,660	4,401,449	0.011055	0	0	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0.000000	0	0	76.03
76.97	07697	CARDIAC REHABILITATION	43,435	813,686	0.053381	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	39,260	4,283,244	0.009166	0	0	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	306,307	28,421,022	0.010777	0	0	91.00
91.01	09101	CIVILLE OUT	36,226	407,310	0.088940	0	0	91.01
91.02	09102	LAKE HILL OUT	0	0	0.000000	0	0	91.02
91.03	09103	NUTRITION COUNSELING	1,314	191,211	0.006872	0	0	91.03
91.04	09104	HUNTLEY OP	687	0	0.000000	0	0	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	124,893	5,152,858	0.024238	0	0	92.00
200.00		Total (lines 50 through 199)	2,998,230	359,882,603		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part III Date/Time Prepared: 11/28/2018 10:09 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	9,666	0 30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	22,554	0 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0 41.00	
200.00		Total (lines 30 through 199)	0	0	0	32,220	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	9,666	14,212	0.68	867 30.00	
31.00	03100	INTENSIVE CARE UNIT		22,554	552	40.86	7 31.00	
41.00	04100	SUBPROVIDER - I RF	0	0	5,858	0.00	0 41.00	
200.00		Total (lines 30 through 199)		32,220	20,622		874 200.00	
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	590					30.00
31.00	03100	INTENSIVE CARE UNIT	286					31.00
41.00	04100	SUBPROVIDER - I RF	0					41.00
200.00		Total (lines 30 through 199)	876					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D Part IV Date/Time Prepared: 11/28/2018 10:09 am
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Cost Center Description	Title XIX			Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
	1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	16,110	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01 03650 VASCULAR LAB	0	0	0	0	0	0	54.01
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0	55.00
57.00 05700 CT SCAN	0	0	0	0	0	0	57.00
58.00 05800 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
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
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 03950 OTHER ANCILLARY SERVICES COST CENTER	0	0	0	0	0	0	76.00
76.02 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	0	76.02
76.03 03951 OCCUPATIONAL HEALTH	0	0	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS							
90.01 09001 OUTPATIENT PROCEDURES	0	0	0	0	0	0	90.01
91.00 09100 EMERGENCY	0	0	0	0	0	161,103	91.00
91.01 09101 C'VILLE OUT	0	0	0	0	0	0	91.01
91.02 09102 LAKE HILL OUT	0	0	0	0	0	0	91.02
91.03 09103 NUTRITION COUNSELING	0	0	0	0	0	0	91.03
91.04 09104 HUNTLEY OP	0	0	0	0	0	0	91.04
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	177,213	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		Title XIX			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	49,457,225	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	19,606,616	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	16,110	16,110	9,327,912	0.001727	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	15,253,597	0.000000	54.00
54.01	03650	VASCULAR LAB	0	0	0	6,560,568	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	8,067,893	0.000000	55.00
57.00	05700	CT SCAN	0	0	0	23,787,596	0.000000	57.00
58.00	05800	MRI	0	0	0	6,742,481	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	23,938,342	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	28,940,836	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	796,994	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,834,823	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	14,302,718	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	5,967,553	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,261,186	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	13,856,395	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,459,653	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	33,162,763	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	31,475,104	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,411,568	0.000000	74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0	0	0	0	0.000000	76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	4,401,449	0.000000	76.02
76.03	03951	OCCUPATIONAL HEALTH	0	0	0	0	0.000000	76.03
76.97	07697	CARDIAC REHABILITATION	0	0	0	813,686	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	4,283,244	0.000000	76.98
OUTPATIENT SERVICE COST CENTERS								
90.01	09001	OUTPATIENT PROCEDURES	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	161,103	161,103	28,421,022	0.005668	91.00
91.01	09101	CVILLE OUT	0	0	0	407,310	0.000000	91.01
91.02	09102	LAKE HILL OUT	0	0	0	0	0.000000	91.02
91.03	09103	NUTRITION COUNSELING	0	0	0	191,211	0.000000	91.03
91.04	09104	HUNTLEY OP	0	0	0	0	0.000000	91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	5,152,858	0.000000	92.00
200.00		Total (lines 50 through 199)	0	177,213	177,213	359,882,603		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0217

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

Worksheet D
Part IV
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		Title XIX			Hospital		PPS
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300 ANESTHESIOLOGY	0.001727	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	03650 VASCULAR LAB	0.000000	0	0	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
57.00	05700 CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800 MRI	0.000000	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
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	03950 OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	0	0	76.03
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
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	0	0	90.01
91.00	09100 EMERGENCY	0.005668	0	0	0	0	91.00
91.01	09101 CIVILLE OUT	0.000000	0	0	0	0	91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	0	0	91.02
91.03	09103 NUTRITION COUNSELING	0.000000	0	0	0	0	91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	0	0	91.04
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: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,212	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,212	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)		12,871	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,973	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		13,703,647	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)		13,703,647	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		13,703,647	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		964.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,795,116	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,795,116	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 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		Hospital		PPS			
1.00		2.00		3.00		4.00	
5.00							
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	2,782,294	552	5,040.39	545	2,747,013	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					11,072,047	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					18,614,176	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)					663,257	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					515,555	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,178,812	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					17,435,364	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,341	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					964.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,293,032	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 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	1,323,619	13,703,647	0.096589	1,293,032	124,893	90.00
91.00	Nursing School cost	0	13,703,647	0.000000	1,293,032	0	91.00
92.00	Allied health cost	9,666	13,703,647	0.000705	1,293,032	912	92.00
93.00	All other Medical Education	0	13,703,647	0.000000	1,293,032	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,858 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,858 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)			5,858 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			4,892 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			7,544,034 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)			7,544,034 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			7,544,034 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,287.82 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,300,015 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)			6,300,015 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 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)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,613,667	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,913,682	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)					422,375	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					125,852	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					548,227	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,365,455	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217 Component CCN: 14-T217		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	505,753	7,544,034	0.067040	0	0	90.00
91.00	Nursing School cost	0	7,544,034	0.000000	0	0	91.00
92.00	Allied health cost	0	7,544,034	0.000000	0	0	92.00
93.00	All other Medical Education	0	7,544,034	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 11/28/2018 10:09 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		14,212	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		14,212	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)		12,871	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)		867	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		13,703,647	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)		13,703,647	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		27 13,703,647	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		964.23	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		835,987	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)		835,987	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 am		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)					42.00	
Intensive Care Type Inpatient Hospital Units							
43.00	2,782,294	552	5,040.39	7	35,283	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)					871,270	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)					83,861	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)					83,861	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					787,409	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					1,341	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					964.23	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,293,032	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0217		Period: From 01/01/2018 To 06/30/2018		Worksheet D-1 Date/Time Prepared: 11/28/2018 10:09 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	1,323,619	13,703,647	0.096589	1,293,032	124,893	90.00
91.00	Nursing School cost	0	13,703,647	0.000000	1,293,032	0	91.00
92.00	Allied health cost	9,666	13,703,647	0.000705	1,293,032	912	92.00
93.00	All other Medical Education	0	13,703,647	0.000000	1,293,032	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 10:09 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	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		20,770,974	30.00
31.00	03100	INTENSIVE CARE UNIT		4,796,885	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.070060	14,631,294	1,025,068 50.00
51.00	05100	RECOVERY ROOM	0.121998	4,963,742	605,567 51.00
53.00	05300	ANESTHESIOLOGY	0.021261	2,189,172	46,544 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.189546	2,226,969	422,113 54.00
54.01	03650	VASCULAR LAB	0.068837	682,622	46,990 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.317476	67,278	21,359 55.00
57.00	05700	CT SCAN	0.028408	2,895,963	82,269 57.00
58.00	05800	MRI	0.056866	829,855	47,191 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.059463	4,200,059	249,748 59.00
60.00	06000	LABORATORY	0.132847	6,238,376	828,750 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.058171	259,626	15,103 62.00
65.00	06500	RESPIRATORY THERAPY	0.140147	2,682,831	375,991 65.00
66.00	06600	PHYSICAL THERAPY	0.100878	1,652,538	166,705 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.060453	692,498	41,864 67.00
68.00	06800	SPEECH PATHOLOGY	0.010461	347,150	3,632 68.00
69.00	06900	ELECTROCARDIOLOGY	0.066282	2,244,572	148,775 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.554545	3,430,272	1,902,240 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.183237	14,914,106	2,732,816 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.267613	5,468,503	1,463,442 73.00
74.00	07400	RENAL DIALYSIS	0.286982	530,318	152,192 74.00
76.00	03950	OTHER ANCILLARY SERVICES COST CENTE	0.000000	0	0 76.00
76.02	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.114772	438,629	50,342 76.02
76.03	03951	OCCUPATIONAL HEALTH	0.000000	0	0 76.03
76.97	07697	CARDIAC REHABILITATION	0.307294	553	170 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.150051	16,542	2,482 76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT PROCEDURES	0.000000	0	0 90.01
91.00	09100	EMERGENCY	0.123146	3,567,808	439,361 91.00
91.01	09101	CVILLE OUT	0.437588	875	383 91.01
91.02	09102	LAKE HILL OUT	0.000000	0	0 91.02
91.03	09103	NUTRITION COUNSELING	1.190930	0	0 91.03
91.04	09104	HUNTLEY OP	0.000000	0	0 91.04
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.250935	800,804	200,950 92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		75,972,955	11,072,047 200.00
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)		75,972,955	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet D-3 Date/Time Prepared: 11/28/2018 10:09 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		16,874,860		41.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.070060	19,484	1,365	50.00
51.00	05100 RECOVERY ROOM	0.121998	5,494	670	51.00
53.00	05300 ANESTHESIOLOGY	0.021261	870	18	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.189546	192,385	36,466	54.00
54.01	03650 VASCULAR LAB	0.068837	92,369	6,358	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.317476	0	0	55.00
57.00	05700 CT SCAN	0.028408	163,967	4,658	57.00
58.00	05800 MRI	0.056866	50,513	2,872	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.059463	4,066	242	59.00
60.00	06000 LABORATORY	0.132847	1,347,563	179,020	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.058171	4,204	245	62.00
65.00	06500 RESPIRATORY THERAPY	0.140147	850,066	119,134	65.00
66.00	06600 PHYSICAL THERAPY	0.100878	4,946,556	498,999	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.060453	3,959,885	239,387	67.00
68.00	06800 SPEECH PATHOLOGY	0.010461	588,410	6,155	68.00
69.00	06900 ELECTROCARDIOLOGY	0.066282	80,995	5,369	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.554545	8,061	4,470	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.183237	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.267613	1,533,088	410,274	73.00
74.00	07400 RENAL DIALYSIS	0.286982	313,271	89,903	74.00
76.00	03950 OTHER ANCILLARY SERVICES COST CENTER	0.000000	0	0	76.00
76.02	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.114772	0	0	76.02
76.03	03951 OCCUPATIONAL HEALTH	0.000000	0	0	76.03
76.97	07697 CARDIAC REHABILITATION	0.307294	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.150051	0	0	76.98
OUTPATIENT SERVICE COST CENTERS					
90.01	09001 OUTPATIENT PROCEDURES	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.123146	12,510	1,541	91.00
91.01	09101 CIVILLE OUT	0.437588	0	0	91.01
91.02	09102 LAKE HILL OUT	0.000000	0	0	91.02
91.03	09103 NUTRITION COUNSELING	1.190930	0	0	91.03
91.04	09104 HUNTLEY OP	0.000000	0	0	91.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.250935	25,986	6,521	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		14,199,743	1,613,667	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)		14,199,743		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments			0 1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	12,034,214		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0		1.04
2.00	Outlier payments for discharges. (see instructions)	259,846		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)	136.59		4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.63	30.00
31.00	Percentage of Medicaid patient days (see instructions)		20.16	31.00
32.00	Sum of lines 30 and 31		23.79	32.00
33.00	Allowable disproportionate share percentage (see instructions)		8.84	33.00
34.00	Disproportionate share adjustment (see instructions)		265,956	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)	0.000000000		0.000000000 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		932,010	0 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		462,174	0 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		462,174	36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0	46.00
47.00	Subtotal (see instructions)		13,022,190	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)		13,022,190	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,044,574	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		30,699	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		25,651	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		24,145	58.00
59.00	Total (sum of amounts on lines 49 through 58)		14,147,259	59.00
60.00	Primary payer payments		3,660	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		14,143,599	61.00
62.00	Deductibles billed to program beneficiaries		1,240,312	62.00
63.00	Coinurance billed to program beneficiaries		38,507	63.00
64.00	Allowable bad debts (see instructions)		125,942	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		81,862	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		90,719	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		12,946,642	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)		-4,695	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/28/2018 10:09 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			12,941,947	71.00
71.01	Sequestration adjustment (see instructions)			258,839	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			12,626,813	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)			56,295	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			247,301	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0217

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 10:09 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	12,034,214	0	12,034,214	0	12,034,214	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	259,846	0	259,846	0	259,846	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
Indirect Medical Education Adjustment								
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
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	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
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0884	0.0884	0.0884	0.0884		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	265,956	0	265,956	0	265,956	11.00
11.01	Uncompensated care payments	36.00	462,174	0	719,336	207,352	926,688	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,022,190	0	12,814,838	207,352	13,022,190	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	13,022,190	0	12,814,838	207,352	13,022,190	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,044,574	0	1,044,574	0	1,044,574	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	13,859,412	207,352	14,066,764	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0217

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

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/28/2018 10:09 am

		Title XVIII			Hospital		PPS	
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	980,301	0	980,301	0	980,301	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	15,846	0	15,846	0	15,846	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	0.0494	0.0494	0.0494	0.0494		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	48,427	0	48,427	0	48,427	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,044,574	0	1,044,574	0	1,044,574	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: 14-0217

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2018 10:09 am

		Title XVIII			Hospital	PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12,034,214	12,034,214		12,034,214	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	259,846	259,846	0	259,846	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
Indirect Medical Education Adjustment							
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
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	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
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0884	0.0884	0.0884		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	265,956	265,956	0	265,956	11.00
11.01	Uncompensated care payments	36.00	462,174	462,174	0	462,174	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	13,022,190	13,022,190	0	13,022,190	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	13,022,190	13,022,190	0	13,022,190	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,044,574	1,044,574	0	1,044,574	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			14,066,764	0	14,066,764	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0217

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

Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/28/2018 10:09 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	980,301	980,301	0	980,301	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	15,846	15,846	0	15,846	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	0.0494	0.0494	0.0494		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	48,427	48,427	0	48,427	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,044,574	1,044,574	0	1,044,574	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	-4,695	-4,695	0	-4,695	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	0	0	0	0	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: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,108	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,908,612	2.00
3.00	OPPS payments		6,756,073	3.00
4.00	Outlier payment (see instructions)		54,972	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		21,480	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,108	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		23,463	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)		23,463	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		23,463	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		17,355	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)		6,108	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)		6,832,525	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,220,797	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)		5,617,836	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)		5,617,836	30.00
31.00	Primary payer payments		2,204	31.00
32.00	Subtotal (line 30 minus line 31)		5,615,632	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		141,877	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		92,220	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		110,479	36.00
37.00	Subtotal (see instructions)		5,707,852	37.00
38.00	MSP-LCC reconciliation amount from PS&R		15	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		5,707,837	40.00
40.01	Sequestration adjustment (see instructions)		114,157	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		5,580,460	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		13,220	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		517	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		126	2.00
3.00	OPPS payments		372	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		6	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		517	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,931	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)		1,931	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		1,931	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,414	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)		517	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)		378	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		895	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)		895	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		895	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		895	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		895	40.00
40.01	Sequestration adjustment (see instructions)		18	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		876	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0217

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

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2018 10:09 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		12,509,059		5,480,923	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		117,754		99,537	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		12,626,813		5,580,460	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		56,295		13,220	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		12,683,108		5,593,680	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0217
Component CCN: 14-T217

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

Worksheet E-1
Part I
Date/Time Prepared:
11/28/2018 10:09 am
PPS

Title XVIII

Subprovider -
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		8,108,650		876	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	08/03/2017	19,444		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		19,444		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,128,094		876	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1	6.01
6.02	SETTLEMENT TO PROGRAM		26,955		0	6.02
7.00	Total Medicare program liability (see instructions)		8,101,139		877	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: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/28/2018 10:09 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 IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0217 Component CCN: 14-T217	Period: From 01/01/2018 To 06/30/2018	Worksheet E-3 Part III Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8,278,120 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0124 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			32,285 3.00
4.00	Outlier Payments			55,174 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			32.364641 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			8,365,579 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			8,365,579 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			8,365,579 19.00
20.00	Deductibles			72,216 20.00
21.00	Subtotal (line 19 minus line 20)			8,293,363 21.00
22.00	Coinsurance			29,480 22.00
23.00	Subtotal (line 21 minus line 22)			8,263,883 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,864 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			2,512 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			8,266,395 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			73 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			8,266,468 32.00
32.01	Sequestration adjustment (see instructions)			165,329 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			8,128,094 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			-26,955 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,917 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			55,174 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 14-0217

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

Worksheet G

Date/Time Prepared:
11/28/2018 10:09 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,073,406	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	18,275,533	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	4,140,111	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,463,327	0	0	0	9.00
10.00	Due from other funds	-973,532	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	23,978,845	0	0	0	11.00
FIXED ASSETS						
12.00	Land	5,020,000	0	0	0	12.00
13.00	Land improvements	1,279,250	0	0	0	13.00
14.00	Accumulated depreciation	-40,280	0	0	0	14.00
15.00	Buildings	46,967,882	0	0	0	15.00
16.00	Accumulated depreciation	-571,832	0	0	0	16.00
17.00	Leasehold improvements	354,250	0	0	0	17.00
18.00	Accumulated depreciation	-12,430	0	0	0	18.00
19.00	Fixed equipment	11,239,236	0	0	0	19.00
20.00	Accumulated depreciation	-453,687	0	0	0	20.00
21.00	Automobiles and trucks	28,000	0	0	0	21.00
22.00	Accumulated depreciation	-1,244	0	0	0	22.00
23.00	Major movable equipment	1,454,708	0	0	0	23.00
24.00	Accumulated depreciation	-826,790	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)	64,437,063	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	864,594	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	3,330,657	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,195,251	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	92,611,159	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,961,560	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	15,107,234	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	17,068,794	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	17,068,794	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	75,542,365				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)	75,542,365	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	92,611,159	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0217

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

Worksheet G-1

Date/Time Prepared:
11/28/2018 10:09 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		59,816,828			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,274,481				2.00
3.00	Total (sum of line 1 and line 2)		63,091,309			0	3.00
4.00	NET ASSET TRANSFERS	239,962		0		0	4.00
5.00	OPENING BALANCE SHEET	12,211,094		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		12,451,056			0	10.00
11.00	Subtotal (line 3 plus line 10)		75,542,365			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		75,542,365			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	NET ASSET TRANSFERS		0				4.00
5.00	OPENING BALANCE SHEET		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0217

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/28/2018 10:09 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	48,663,621		48,663,621	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	20,205,810		20,205,810	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)	68,869,431		68,869,431	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,614,105		10,614,105	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)	10,614,105		10,614,105	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	79,483,536		79,483,536	17.00
18.00	Ancillary services	173,895,648	162,349,637	336,245,285	18.00
19.00	Outpatient services	0	23,637,316	23,637,316	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	MISC INCOME	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	253,379,184	185,986,953	439,366,137	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,225,734		29.00
30.00	BALANCING AMOUNT	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)		70,225,734		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0217

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

Worksheet G-3

Date/Time Prepared:
11/28/2018 10:09 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	439,366,137	1.00
2.00	Less contractual allowances and discounts on patients' accounts	367,619,877	2.00
3.00	Net patient revenues (line 1 minus line 2)	71,746,260	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,225,734	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,520,526	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	51,397	6.00
7.00	Income from investments	131,203	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	234,818	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	46,212	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	1,290,325	24.00
25.00	Total other income (sum of lines 6-24)	1,753,955	25.00
26.00	Total (line 5 plus line 25)	3,274,481	26.00
27.00	OTHER EXPENSES (SPECIFY)	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)	3,274,481	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0217	Period: From 01/01/2018 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/28/2018 10:09 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		980,301	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		15,846	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)		74.16	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)		3.63	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		20.16	8.00
9.00	Sum of lines 7 and 8		23.79	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.94	10.00
11.00	Disproportionate share adjustment (see instructions)		48,427	11.00
12.00	Total prospective capital payments (see instructions)		1,044,574	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00