

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: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/27/2019 4:58 pm
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**PART I - COST REPORT STATUS**

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/27/2019	Time: 4:58 pm
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORTHWEST COMMUNITY HOSPITAL ( 14-0252 ) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 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) JOHN SKEANS  
Officer or Administrator of Provider(s)

EXECUTIVE VP/CFO  
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	
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	2,556,335	-31,777	0	0	1.00
2.00 Subprovider - IPF	0	12,461	0		0	2.00
3.00 Subprovider - IRF	0	40,780	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
9.00 HOME HEALTH AGENCY I	0	0	-1,894		0	9.00
200.00 Total	0	2,609,576	-33,671	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-MEDI CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:58 pm
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1.00 Hospital and Hospital Health Care Complex Address:		2.00		3.00		4.00				
1.00	Street: 800 WEST CENTRAL ROAD	PO Box:		Zip Code: 60005		County: COOK				1.00
2.00	City: ARLINGTON HEIGHTS	State: IL								2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	NORTHWEST COMMUNITY HOSPITAL	140252	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	NWCH PSYCHIATRIC UNIT	14S252	16974	4	11/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	NWC REHAB	14T252	16974	5	10/01/2015	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	NORTHWEST COMMUNITY HOME CARE SERVIC	147094	16974		07/01/1966	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2017	09/30/2018			20.00
21.00	Type of Control (see instructions)					2				21.00

						1.00	2.00	3.00		
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Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252			Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:58 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,028	1,026	21	0	5,804	91		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	187	7	0	0	89			25.00	
						Urban/Rural S		Date of Geogr		
						1.00		2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00	
						Beginning:		Ending:		
						1.00		2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								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), (ii), or (iii)? 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), (ii), or (iii)? 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		
						1.00		2.00		
								XIX		
								3.00		
<b>Prospective Payment System (PPS)-Capital</b>										
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	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
<b>Teaching Hospitals</b>										
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00	

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		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
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 FTE Count	IME	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	5.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00		0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00		0.00	61.20
							1.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovi- der Site	Unweighted FTEs in Hospi- tal	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
<b>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.</b>							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00	
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00	
					1.00	2.00	3.00	
<b>Inpatient Psychiatric Facility PPS</b>								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		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)				N	N	0	71.00
<b>Inpatient Rehabilitation Facility PPS</b>								
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	N	0	76.00

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				1.00	
<b>Long Term Care Hospital PPS</b>					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N	81.00	
<b>TEFRA Providers</b>					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00	
		V	XIX		
		1.00	2.00		
<b>Title V and XIX Services</b>					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01	
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	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.	N	N	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.	N	N	98.06	
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a CAH?	N		105.00	
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				109.00
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:58 pm		
		1.00	2.00			
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00
		1.00	2.00	3.00		
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	5,531,211	0	0		
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00
<b>Transplant Center Information</b>						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
<b>All Providers</b>						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/27/2019 4:58 pm			
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
				1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			Y	N	145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40	
				1.00			
<b>Multi campus</b>							
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						
				1.00			
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				9.99	169.00	
				Beginning	Ending		
				1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2017	12/31/2017	170.00	
				1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			N		171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 4:58 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					Y	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	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	02/11/2019	Y	02/11/2019		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: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 4:58 pm	
		Description	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	0	1.00	3.00	20.00
			N	N	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
			1.00	2.00	
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TONY		LEONE	41.00
42.00	Enter the employer/company name of the cost report preparer.	TONY LEONE, CPA			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	847/275-1023		TONY@LEONE-CONSULTING.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/27/2019 4:58 pm
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONSULTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	328	125,560	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)		328	125,560	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	60	21,900	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 NEONATAL INTENSIVE CARE UNIT	35.00	8	2,920	0.00	0	12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		396	150,380	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	52	18,980		0	16.00
17.00 SUBPROVIDER - IRF	41.00	33	6,205		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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		481				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: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	32,864	1,992	67,997			1.00
2.00 HMO and other (see instructions)	7,401	6,778				2.00
3.00 HMO IPF Subprovider	595	2,638				3.00
4.00 HMO IRF Subprovider	493	96				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	32,864	1,992	67,997			7.00
8.00 INTENSIVE CARE UNIT	4,158	540	8,136			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 NEONATAL INTENSIVE CARE UNIT	0	818	3,397			12.00
13.00 NURSERY		842	5,059			13.00
14.00 Total (see instructions)	37,022	4,192	84,589	0.00	2,516.78	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,842	1,865	13,799	0.00	89.76	16.00
17.00 SUBPROVIDER - IRF	3,801	187	5,906	0.00	29.74	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	32,959	0	49,375	0.00	58.37	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)			0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	2,694.65	27.00
28.00 Observation Bed Days		0	2,430			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	91	620			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: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	8,376	671	19,530	1.00
2.00 HMO and other (see instructions)			1,650	1,646		2.00
3.00 HMO IPF Subprovider				425		3.00
4.00 HMO IRF Subprovider				10		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 NEONATAL INTENSIVE CARE UNIT						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	8,376	671	19,530	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	240	236	1,778	16.00
17.00 SUBPROVIDER - IRF	0.00	0	306	8	485	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	196,625,919	-1,751,613	194,874,306	5,604,894.00	34.77
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		16,556,914	301,753	16,858,667	492,537.00	34.23
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		4,810,467	0	4,810,467	78,693.00	61.13
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		3,977,724	0	3,977,724	41,856.00	95.03
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		44,949,193	0	44,949,193		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		4,309,957	0	4,309,957		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits Department	4.00	2,638,953	-270	2,638,683	42,353.00	62.30
27.00	Administrative & General	5.00	35,342,729	-277,043	35,065,686	856,860.00	40.92

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)	4,107,423	0	4,107,423	37,670.00	109.04	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	3,772,946	0	3,772,946	135,178.00	27.91	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	3,380,224	-87,235	3,292,989	224,361.00	14.68	32.00
33.00	Housekeeping under contract (see instructions)	923,373	0	923,373	16,640.00	55.49	33.00
34.00	Dietary	2,908,598	-1,236,721	1,671,877	101,224.00	16.52	34.00
35.00	Dietary under contract (see instructions)	525,092	0	525,092	10,400.00	50.49	35.00
36.00	Cafeteria	0	1,236,721	1,236,721	74,878.00	16.52	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	8,178,343	-117,458	8,060,885	183,711.00	43.88	38.00
39.00	Central Services and Supply	2,835,952	-8,992	2,826,960	115,590.00	24.46	39.00
40.00	Pharmacy	4,313,046	0	4,313,046	98,394.00	43.83	40.00
41.00	Medical Records & Medical Records Library	2,454,359	-24,000	2,430,359	81,594.00	29.79	41.00
42.00	Social Service	0	0	0	0.00	0.00	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/27/2019 4:58 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	202,181,807	-1,751,613	200,430,194	5,669,604.00	35.35	1.00
2.00	Excluded area salaries (see instructions)	16,556,914	301,753	16,858,667	492,537.00	34.23	2.00
3.00	Subtotal salaries (line 1 minus line 2)	185,624,893	-2,053,366	183,571,527	5,177,067.00	35.46	3.00
4.00	Subtotal other wages & related costs (see inst.)	8,788,191	0	8,788,191	120,549.00	72.90	4.00
5.00	Subtotal wage-related costs (see inst.)	44,949,193	0	44,949,193	0.00	24.49	5.00
6.00	Total (sum of lines 3 thru 5)	239,362,277	-2,053,366	237,308,911	5,297,616.00	44.80	6.00
7.00	Total overhead cost (see instructions)	71,381,038	-514,998	70,866,040	1,978,853.00	35.81	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 2/27/2019 4:58 pm
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions		6,786,859	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)		3,282,439	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		20,828,073	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		848,560	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		519,505	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)		468,852	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,987,118	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		13,729,863	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		240,535	19.00
20.00	State or Federal Unemployment Taxes		3,758	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		563,587	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		49,259,149	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COST		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-3 Part V Date/Time Prepared: 2/27/2019 4:58 pm
Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost	4,810,467	49,259,149	1.00
2.00	Hospital	4,810,467	44,949,193	2.00
3.00	Subprovider - IPF	0	1,619,787	3.00
4.00	Subprovider - IRF	0	527,637	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	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	2,162,532	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 14-0252 Component CCN: 14-7094		Period: From 10/01/2017 To 09/30/2018		Worksheet S-4 Date/Time Prepared: 2/27/2019 4:58 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			COOK		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,435	0	1,061	3,496	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,660.00	0.00	1,291.00	2,951.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			22.13	0.00	22.13	5.00
6.00	Direct Nursing Service			20.94	0.00	20.94	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			15.04	0.00	15.04	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.28	0.00	2.28	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.28	0.00	0.28	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			1.24	0.00	1.24	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.56	0.00	1.56	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	CONTINUUM PERSONNEL			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
20.01				20994			20.01
20.02				29404			20.02
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	12,956	996	404	211	14,567	21.00
22.00	Skilled Nursing Visit Charges	2,409,816	185,256	74,958	39,246	2,709,276	22.00
23.00	Physical Therapy Visits	12,720	536	112	212	13,580	23.00
24.00	Physical Therapy Visit Charges	3,408,960	143,648	30,016	56,816	3,639,440	24.00
25.00	Occupational Therapy Visits	2,688	358	13	52	3,111	25.00
26.00	Occupational Therapy Visit Charges	720,384	95,944	3,484	13,936	833,748	26.00
27.00	Speech Pathology Visits	323	107	3	10	443	27.00
28.00	Speech Pathology Visit Charges	88,976	28,676	804	2,680	121,136	28.00
29.00	Medical Social Service Visits	120	14	1	4	139	29.00
30.00	Medical Social Service Visit Charges	29,160	3,402	243	972	33,777	30.00
31.00	Home Health Aide Visits	901	203	4	11	1,119	31.00
32.00	Home Health Aide Visit Charges	121,635	27,405	540	1,485	151,065	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	29,708	2,214	537	500	32,959	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	6,778,931	484,331	110,045	115,135	7,488,442	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,881		200	34	2,115	36.00
37.00	Total Number of Outlier Episodes		51		3	54	37.00
38.00	Total Non-Routine Medical Supply Charges	264,271	52,517	14,194	1,645	332,627	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-7

Date/Time Prepared:  
2/27/2019 4:58 pm

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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet S-7

Date/Time Prepared:  
2/27/2019 4:58 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00
				CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
				1.00	2.00	
SNF SERVICES						
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).					201.00
			Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
			1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)						
202.00	Staffing		0	0.00		202.00
203.00	Recruitment		0	0.00		203.00
204.00	Retention of employees		0	0.00		204.00
205.00	Training		0	0.00		205.00
206.00	OTHER (SPECIFY)		0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/27/2019 4:58 pm
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.245747	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		23,779,964	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	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		142,794,625	6.00	
7.00	Medicaid cost (line 1 times line 6)		35,091,351	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)		11,311,387	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)		11,311,387	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)	22,745,478	3,859,869	26,605,347	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,589,633	3,859,869	9,449,502	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	5,589,633	3,859,869	9,449,502	23.00
			1.00		
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		19,442,069	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,413,007	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		2,173,856	27.01	
28.00	Non-Medicare bad debt expense (see instructions)		17,268,213	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		5,004,461	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		14,453,963	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		25,765,350	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet A Date/Time Prepared: 2/27/2019 4:58 pm		
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		14,764,600	14,764,600	8,592,510	23,357,110	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		18,324,439	18,324,439	0	18,324,439	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,638,953	30,372,879	33,011,832	0	33,011,832	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,342,729	60,020,136	95,362,865	-953,592	94,409,273	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,772,946	14,274,311	18,047,257	75,975	18,123,232	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	3,380,224	3,614,062	6,994,286	74,449	7,068,735	9.00
10.00	01000	DIETARY	2,908,598	2,685,933	5,594,531	-2,378,766	3,215,765	10.00
11.00	01100	CAFETERIA	0	0	0	2,378,766	2,378,766	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,178,343	1,011,563	9,189,906	0	9,189,906	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,835,952	359,564	3,195,516	1,285,549	4,481,065	14.00
15.00	01500	PHARMACY	4,313,046	10,446,426	14,759,472	-9,715,763	5,043,709	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,454,359	2,579,352	5,033,711	-67	5,033,644	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	760,457	575,751	1,336,208	-618,310	717,898	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	30,178,751	4,957,605	35,136,356	-4,205,942	30,930,414	30.00
31.00	03100	INTENSIVE CARE UNIT	8,498,124	2,888,497	11,386,621	-1,111,633	10,274,988	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	2,215,699	951,899	3,167,598	-687,688	2,479,910	35.00
40.00	04000	SUBPROVIDER - I PF	6,192,005	1,588,897	7,780,902	-14,332	7,766,570	40.00
41.00	04100	SUBPROVIDER - I RF	1,922,531	2,847,657	4,770,188	-2,661,993	2,108,195	41.00
43.00	04300	NURSERY	0	0	0	2,010,598	2,010,598	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	12,597,722	28,569,352	41,167,074	-22,953,796	18,213,278	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,460,304	1,390,290	4,850,594	-11,776	4,838,818	52.00
53.00	05300	ANESTHESIOLOGY	176,449	730,466	906,915	-558,913	348,002	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,616,786	8,361,273	22,978,059	-2,967,367	20,010,692	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,719,745	842,099	2,561,844	-49,322	2,512,522	54.01
56.01	03480	ONCOLOGY	1,460,872	10,625,038	12,085,910	-88,327	11,997,583	56.01
60.00	06000	LABORATORY	7,373,651	9,524,380	16,898,031	-297,284	16,600,747	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	467,621	2,476,028	2,943,649	-101	2,943,548	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,337,896	629,445	2,967,341	-150,823	2,816,518	65.00
66.00	06600	PHYSICAL THERAPY	7,374,220	2,076,162	9,450,382	-462,709	8,987,673	66.00
66.01	06601	I P REHAB THERAPIES	0	0	0	2,563,664	2,563,664	66.01
69.00	06900	ELECTROCARDIOLOGY	4,371,900	2,352,051	6,723,951	-282,978	6,440,973	69.00
69.01	03630	CARDIAC CATH LAB	1,941,829	8,468,894	10,410,723	-8,097,072	2,313,651	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	24,347,120	24,347,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,757,356	15,757,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,324,181	10,324,181	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	1,789,884	1,789,884	-11,505	1,778,379	74.00
76.97	07697	CARDIAC REHABILITATION	752,137	255,554	1,007,691	-6,380	1,001,311	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,895,520	2,174,526	4,070,046	-483,988	3,586,058	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	1,686,902	126,433	1,813,335	-13,501	1,799,834	90.02
91.00	09100	EMERGENCY	8,490,979	3,891,552	12,382,531	-2,001,465	10,381,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	2,626,748	327,798	2,954,546	0	2,954,546	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	5,149,767	1,914,967	7,064,734	560	7,065,294	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE		7,929,614	7,929,614	-7,929,614	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	194,093,765	266,719,377	460,813,142	-1,304,279	459,508,863	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144,799	193,069	337,868	0	337,868	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES			Provider CCN: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet A Date/Time Prepared: 2/27/2019 4:58 pm	
Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.01	19201	DAY SURGERY CENTER	0	-209	-209	210	1	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	1,026,046	98,118	1,124,164	0	1,124,164	192.02
192.03	19203	MOBILE DENTAL CLINIC	239,945	61,413	301,358	0	301,358	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	896,720	896,720	192.04
194.00	07950	CORPORATE HEALTH	114,539	41,913	156,452	0	156,452	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	407,349	407,349	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	698,701	2,251,128	2,949,829	0	2,949,829	194.03
194.04	07954	OP PHARMACY	308,124	1,710,470	2,018,594	0	2,018,594	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	196,625,919	271,075,279	467,701,198	0	467,701,198	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	17,390,917	40,748,027	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	178,026	18,502,465	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	33,011,832	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-22,822,763	71,586,510	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	-4,699	18,118,533	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,068,735	9.00
10.00	01000	DIETARY	-1,690,621	1,525,144	10.00
11.00	01100	CAFETERIA	-1,690,621	688,145	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-14,829	9,175,077	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,481,065	14.00
15.00	01500	PHARMACY	0	5,043,709	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,569	5,032,075	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-579,612	138,286	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-654,813	30,275,601	30.00
31.00	03100	INTENSIVE CARE UNIT	-135,771	10,139,217	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	2,479,910	35.00
40.00	04000	SUBPROVIDER - I PF	-104,984	7,661,586	40.00
41.00	04100	SUBPROVIDER - I RF	0	2,108,195	41.00
43.00	04300	NURSERY	0	2,010,598	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-111,645	18,101,633	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,838,818	52.00
53.00	05300	ANESTHESIOLOGY	0	348,002	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,397	19,990,295	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	2,512,522	54.01
56.01	03480	ONCOLOGY	-42,527	11,955,056	56.01
60.00	06000	LABORATORY	-230,352	16,370,395	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	2,943,548	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,816,518	65.00
66.00	06600	PHYSICAL THERAPY	-60,287	8,927,386	66.00
66.01	06601	I P REHAB THERAPIES	0	2,563,664	66.01
69.00	06900	ELECTROCARDIOLOGY	-545,219	5,895,754	69.00
69.01	03630	CARDIAC CATH LAB	-17,770	2,295,881	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	24,347,120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,757,356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,324,181	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	1,778,379	74.00
76.97	07697	CARDIAC REHABILITATION	-3,200	998,111	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	3,586,058	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	1,799,834	90.02
91.00	09100	EMERGENCY	-28,000	10,353,066	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	2,954,546	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	7,065,294	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-11,190,736	448,318,127	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	337,868	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	1	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	1,124,164	192.02

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.03	19203	MOBILE DENTAL CLINIC	0	301,358	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	896,720	192.04
194.00	07950	CORPORATE HEALTH	-17,664	138,788	194.00
194.01	07951	MARKETING/COMMUNICATION	0	407,349	194.01
194.02	07952	FOUNDATION	0	0	194.02
194.03	07953	OTHER NRCC	-232,082	2,717,747	194.03
194.04	07954	OP PHARMACY	0	2,018,594	194.04
200.00		TOTAL (SUM OF LINES 118 through 199)	-11,440,482	456,260,716	200.00

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-6

Date/Time Prepared:  
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		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - SHARED EXPENSES</b>					
1.00	CAFETERIA	11.00	1,236,721	1,142,045	1.00
	TOTALS		1,236,721	1,142,045	
<b>B - FLOAT POOL</b>					
1.00	INTENSIVE CARE UNIT	31.00	25,929	1,903	1.00
2.00	SUBPROVIDER - IPF	40.00	8,527	626	2.00
3.00	NEONATAL INTENSIVE CARE UNIT	35.00	2,262	166	3.00
4.00	OPERATING ROOM	50.00	522	39	4.00
5.00	EMERGENCY	91.00	2,610	192	5.00
6.00	HOME HEALTH AGENCY	101.00	522	38	6.00
	TOTALS		40,372	2,964	
<b>C - TREATMENT CENTER LEASE EXP</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	251,936	1.00
	TOTALS		0	251,936	
<b>D - COST OF MEDICAL SUPPLIES SOLD</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	24,347,120	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	15,757,356	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,291,060	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
	TOTALS		0	41,395,536	
<b>E - COST OF DRUGS SOLD</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,324,181	1.00
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
13.00		0.00	0	0	13.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
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
	TOTALS		0	10,324,181	

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-6  
Date/Time Prepared:  
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		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
<b>F - PARAMEDICAL EDUCATION</b>					
1.00	EMS CONTINUING EDUCATION	192.04	519,844	376,876	1.00
	TOTALS		519,844	376,876	
<b>H - SALT CREEK OCCUPANCY COSTS</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	103,556	1.00
2.00	OPERATION OF PLANT	7.00	0	75,975	2.00
3.00	HOUSEKEEPING	9.00	0	74,449	3.00
	TOTALS		0	253,980	
<b>I - FLU VACCINES</b>					
1.00	OUTPATIENT TREATMENT CENTERS	90.01	30,839	129,448	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
	TOTALS		30,839	129,448	
<b>J - PROPERTY INSURANCE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	307,404	1.00
2.00	DAY SURGERY CENTER	192.01	0	210	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	307,614	
<b>K - LDR COST ALLOCATION</b>					
1.00	NURSERY	43.00	1,727,344	283,254	1.00
2.00		0.00	0	0	2.00
	TOTALS		1,727,344	283,254	
<b>L - EMT CLINICAL EDUCATORS</b>					
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	278,410	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
	TOTALS		278,410	0	
<b>M - INTEREST EXPENSE</b>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	7,929,614	1.00
	TOTALS		0	7,929,614	
<b>N - TEMP HELP</b>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	270	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	189,150	2.00
3.00	HOUSEKEEPING	9.00	0	87,235	3.00
4.00	NURSING ADMINISTRATION	13.00	0	117,458	4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	8,992	5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	24,000	6.00
7.00	ADULTS & PEDIATRICS	30.00	0	85,257	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	59,672	8.00
9.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	31,809	9.00
10.00	SUBPROVIDER - IPF	40.00	0	50,948	10.00
11.00	OPERATING ROOM	50.00	0	251,203	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	64,300	12.00
13.00	ONCOLOGY	56.01	0	10,701	13.00
14.00	LABORATORY	60.00	0	228,229	14.00
15.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	2,691	15.00
16.00	RESPIRATORY THERAPY	65.00	0	143,146	16.00
17.00	PHYSICAL THERAPY	66.00	0	139,759	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	26,143	18.00
19.00	CARDIAC CATH LAB	69.01	0	91,808	19.00
20.00	PARTIAL HOSPITALIZATION PROGRAM	90.02	0	79,757	20.00
21.00	EMERGENCY	91.00	0	45,675	21.00
22.00	RESIDENTIAL TREATMENT CENTER	192.02	0	2,316	22.00
23.00	MOBILE DENTAL CLINIC	192.03	0	10,926	23.00
24.00	MARKETING/COMMUNICATION	194.01	0	168	24.00
	TOTALS		0	1,751,613	
<b>O - MARKETING RECLASS</b>					
1.00	MARKETING/COMMUNICATION	194.01	87,893	319,456	1.00
	TOTALS		87,893	319,456	
<b>P - IP REHAB THERAPY</b>					
1.00	IP REHAB THERAPIES	66.01	0	2,563,664	1.00
	TOTALS		0	2,563,664	
500.00	Grand Total: Increases		3,921,423	67,032,181	500.00

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-6  
Date/Time Prepared:  
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Decreases						
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.	
6.00	7.00	8.00	9.00	10.00		
<b>A - SHARED EXPENSES</b>						
1.00	DIETARY	10.00	1,236,721	1,142,045	0	1.00
	TOTALS		1,236,721	1,142,045		
<b>B - FLOAT POOL</b>						
1.00	ADULTS & PEDIATRICS	30.00	40,372	2,964	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
	TOTALS		40,372	2,964		
<b>C - TREATMENT CENTER LEASE EXP</b>						
1.00	OUTPATIENT TREATMENT CENTERS	90.01	0	251,936	10	1.00
	TOTALS		0	251,936		
<b>D - COST OF MEDICAL SUPPLIES SOLD</b>						
1.00		0.00	0	0	0	1.00
2.00	PHARMACY	15.00	0	42,588	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	67	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	2,573,377	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	1,061,913	0	5.00
6.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	171,142	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	13,841	0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	96,004	0	8.00
9.00	OPERATING ROOM	50.00	0	10,476,074	0	9.00
10.00	ANESTHESIOLOGY	53.00	0	492,398	0	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,992,146	0	11.00
12.00	OFFSITE-DIAGNOSTIC SERVICES	54.01	0	47,393	0	12.00
13.00	ONCOLOGY	56.01	0	88,327	0	13.00
14.00	LABORATORY	60.00	0	296,375	0	14.00
15.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	101	0	15.00
16.00	RESPIRATORY THERAPY	65.00	0	149,292	0	16.00
17.00	PHYSICAL THERAPY	66.00	0	258,464	0	17.00
18.00	ELECTROCARDIOLOGY	69.00	0	98,678	0	18.00
19.00	CARDIAC CATH LAB	69.01	0	5,332,574	0	19.00
20.00	RENAL DIALYSIS	74.00	0	11,505	0	20.00
21.00	CARDIAC REHABILITATION	76.97	0	6,353	0	21.00
22.00	OUTPATIENT TREATMENT CENTERS	90.01	0	153,958	0	22.00
23.00	PARTIAL HOSPITALIZATION PROGRAM	90.02	0	12,725	0	23.00
24.00	EMERGENCY	91.00	0	1,755,618	0	24.00
25.00	CENTRAL SERVICES & SUPPLY	14.00	0	5,511	0	25.00
26.00	ADULTS & PEDIATRICS	30.00	0	2,859	0	26.00
27.00	INTENSIVE CARE UNIT	31.00	0	57,743	0	27.00
28.00	OPERATING ROOM	50.00	0	12,246,023	0	28.00
29.00	ANESTHESIOLOGY	53.00	0	25,638	0	29.00
30.00	RADIOLOGY-DIAGNOSTIC	54.00	0	967,187	0	30.00
31.00	PHYSICAL THERAPY	66.00	0	193,941	0	31.00
32.00	CARDIAC CATH LAB	69.01	0	2,764,498	0	32.00
33.00	EMERGENCY	91.00	0	1,223	0	33.00
	TOTALS		0	41,395,536		
<b>E - COST OF DRUGS SOLD</b>						
1.00	PHARMACY	15.00	0	9,543,727	0	1.00
3.00	ADULTS & PEDIATRICS	30.00	0	57,970	0	3.00
4.00	INTENSIVE CARE UNIT	31.00	0	10,099	0	4.00
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	2,338	0	5.00
6.00	SUBPROVIDER - IPF	40.00	0	403	0	6.00
7.00	SUBPROVIDER - IRF	41.00	0	2,325	0	7.00
8.00	OPERATING ROOM	50.00	0	214,316	0	8.00
9.00	ANESTHESIOLOGY	53.00	0	40,877	0	9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,034	0	10.00
11.00	OFFSITE-DIAGNOSTIC SERVICES	54.01	0	1,929	0	11.00
13.00	LABORATORY	60.00	0	909	0	13.00
15.00	RESPIRATORY THERAPY	65.00	0	1,531	0	15.00
16.00	PHYSICAL THERAPY	66.00	0	10,304	0	16.00
17.00	ELECTROCARDIOLOGY	69.00	0	184,300	0	17.00
20.00	CARDIAC REHABILITATION	76.97	0	27	0	20.00
21.00	OUTPATIENT TREATMENT CENTERS	90.01	0	223,030	0	21.00
22.00	PARTIAL HOSPITALIZATION PROGRAM	90.02	0	776	0	22.00
23.00	EMERGENCY	91.00	0	21,286	0	23.00
	TOTALS		0	10,324,181		

RECLASSIFICATIONS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-6  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>F - PARAMEDICAL EDUCATION</b>							
1.00	PARAMED ED PRGM-(SPECIFY)	23.00	519,844	376,876	0		1.00
	TOTALS		519,844	376,876			
<b>H - SALT CREEK OCCUPANCY COSTS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	103,556	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	75,975	0		2.00
3.00	ADMINISTRATIVE & GENERAL	5.00	0	74,449	0		3.00
	TOTALS		0	253,980			
<b>I - FLU VACCINES</b>							
1.00	PHARMACY	15.00	0	129,448	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	15,922	0	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	146	0	0		3.00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	1,313	0	0		4.00
5.00	SUBPROVIDER - IPF	40.00	36	0	0		5.00
6.00	EMERGENCY	91.00	13,422	0	0		6.00
	TOTALS		30,839	129,448			
<b>J - PROPERTY INSURANCE</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	292,263	12		1.00
2.00		0.00	0	0	0		2.00
3.00	OUTPATIENT TREATMENT CENTERS	90.01	0	15,351	0		3.00
	TOTALS		0	307,614			
<b>K - LDR COST ALLOCATION</b>							
1.00	NEONATAL INTENSIVE CARE UNIT	35.00	381,348	133,975	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	1,345,996	149,279	0		2.00
	TOTALS		1,727,344	283,254			
<b>L - EMT CLINICAL EDUCATORS</b>							
1.00	ADULTS & PEDIATRICS	30.00	17,203	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	9,564	0	0		2.00
3.00	SUBPROVIDER - IPF	40.00	9,205	0	0		3.00
4.00	OPERATING ROOM	50.00	17,944	0	0		4.00
5.00	DELIVERY ROOM & LABOR ROOM	52.00	11,776	0	0		5.00
6.00	EMERGENCY	91.00	212,718	0	0		6.00
	TOTALS		278,410	0			
<b>M - INTEREST EXPENSE</b>							
1.00	INTEREST EXPENSE	113.00	0	7,929,614	11		1.00
	TOTALS		0	7,929,614			
<b>N - TEMP HELP</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	270	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	189,150	0	0		2.00
3.00	HOUSEKEEPING	9.00	87,235	0	0		3.00
4.00	NURSING ADMINISTRATION	13.00	117,458	0	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	8,992	0	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	24,000	0	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	85,257	0	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	59,672	0	0		8.00
9.00	NEONATAL INTENSIVE CARE UNIT	35.00	31,809	0	0		9.00
10.00	SUBPROVIDER - IPF	40.00	50,948	0	0		10.00
11.00	OPERATING ROOM	50.00	251,203	0	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	64,300	0	0		12.00
13.00	ONCOLOGY	56.01	10,701	0	0		13.00
14.00	LABORATORY	60.00	228,229	0	0		14.00
15.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	2,691	0	0		15.00
16.00	RESPIRATORY THERAPY	65.00	143,146	0	0		16.00
17.00	PHYSICAL THERAPY	66.00	139,759	0	0		17.00
18.00	ELECTROCARDIOLOGY	69.00	26,143	0	0		18.00
19.00	CARDIAC CATH LAB	69.01	91,808	0	0		19.00
20.00	PARTIAL HOSPITALIZATION PROGRAM	90.02	79,757	0	0		20.00
21.00	EMERGENCY	91.00	45,675	0	0		21.00
22.00	RESIDENTIAL TREATMENT CENTER	192.02	2,316	0	0		22.00
23.00	MOBILE DENTAL CLINIC	192.03	10,926	0	0		23.00
24.00	MARKETING/COMMUNICATION	194.01	168	0	0		24.00
	TOTALS		1,751,613	0			
<b>O - MARKETING RECLASS</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	87,893	319,456	0		1.00
	TOTALS		87,893	319,456			
<b>P - IP REHAB THERAPY</b>							
1.00	SUBPROVIDER - IRF	41.00	0	2,563,664	0		1.00
	TOTALS		0	2,563,664			
500.00	Grand Total: Decreases		5,673,036	65,280,568			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	89,072	0	0	0	1.00
2.00	Land Improvements	14,474,756	305,056	0	305,056	2.00
3.00	Buildings and Fixtures	307,551,751	7,266,953	0	7,266,953	3.00
4.00	Building Improvements	3,452,928	37,204	0	37,204	4.00
5.00	Fixed Equipment	212,603,315	2,754,121	0	2,754,121	5.00
6.00	Movable Equipment	195,493,728	35,730,458	0	35,730,458	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	733,665,550	46,093,792	0	46,093,792	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	733,665,550	46,093,792	0	46,093,792	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	89,072	0			1.00
2.00	Land Improvements	14,779,812	0			2.00
3.00	Buildings and Fixtures	314,818,704	0			3.00
4.00	Building Improvements	3,480,507	0			4.00
5.00	Fixed Equipment	215,331,538	0			5.00
6.00	Movable Equipment	230,280,364	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	778,779,997	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	778,779,997	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	14,764,600	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	18,324,439	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	33,089,039	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	14,764,600				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,324,439				2.00
3.00	Total (sum of lines 1-2)	0	33,089,039				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	548,499,633	0	548,499,633	0.704306	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	230,280,364	0	230,280,364	0.295694	0	2.00
3.00	Total (sum of lines 1-2)	778,779,997	0	778,779,997	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	19,513,045	355,492	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	18,502,465	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	38,015,510	355,492	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	20,572,086	307,404	0	0	40,748,027	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	18,502,465	2.00
3.00	Total (sum of lines 1-2)	20,572,086	307,404	0	0	59,250,492	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-8

Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-48,604		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-4,524		OPERATION OF PLANT	7.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,526,695				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1		0			0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-1,690,621		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts			0		0.00	0	18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-8  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.		
			Cost Center	Line #			
			1.00	2.00			3.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	0	33.00
35.00 PHO EXPENSE	A	-150,478	ADMINISTRATIVE & GENERAL	5.00		0	35.00
38.00 LOBBYING PORTION OF DUES	A	-51,071	ADMINISTRATIVE & GENERAL	5.00		0	38.00
39.00 PROVIDER ASSESSMENT REBATE	A	-20,362,100	ADMINISTRATIVE & GENERAL	5.00		0	39.00
41.14 PARAMED EDUCATION TUITION INCOM	B	-579,612	PARAMED ED PRGM-(SPECIFY)	23.00		0	41.14
41.88 PIANO DEPRECIATION	A	-1,371	CAP REL COSTS-MVBLE EQUIP	2.00		9	41.88
42.00 WELLNESS CENTER RENT TO COST	A	232,445	PHYSICAL THERAPY	66.00		0	42.00
42.01 WELLNESS CENTER RENT TO COST	A	2,073	CARDIAC REHABILITATION	76.97		0	42.01
45.01 MISC OPERATING INCOME	B	-1,987,293	ADMINISTRATIVE & GENERAL	5.00		0	45.01
45.02 MISC OPERATING INCOME	B	-175	OPERATION OF PLANT	7.00		0	45.02
45.03 MISC OPERATING INCOME	B	-1,690,621	DIETARY	10.00		0	45.03
45.04 MISC OPERATING INCOME	B	45,417	NURSING ADMINISTRATION	13.00		0	45.04
45.05 MISC OPERATING INCOME	B	-1,569	MEDICAL RECORDS & LIBRARY	16.00		0	45.05
45.06 MISC OPERATING INCOME	B	-56,745	ADULTS & PEDIATRICS	30.00		0	45.06
45.07 MISC OPERATING INCOME	B	-104,984	SUBPROVIDER - I/PF	40.00		0	45.07
45.08 MISC OPERATING INCOME	B	-50,875	OPERATING ROOM	50.00		0	45.08
45.09 MISC OPERATING INCOME	B	-8,131	RADIOLOGY-DIAGNOSTIC	54.00		0	45.09
45.10 MISC OPERATING INCOME	B	-15,240	ONCOLOGY	56.01		0	45.10
45.11 MISC OPERATING INCOME	B	-56,250	LABORATORY	60.00		0	45.11
45.14 MISC OPERATING INCOME	B	-20	PHYSICAL THERAPY	66.00		0	45.14
45.16 MISC OPERATING INCOME	B	-77,091	ELECTROCARDIOLOGY	69.00		0	45.16
45.17 MISC OPERATING INCOME	B	-740	CARDIAC REHABILITATION	76.97		0	45.17
45.18 OFFSET RESEARCH COSTS	A	-60,246	NURSING ADMINISTRATION	13.00		0	45.18
45.26 NON ALLOWABLE TRAVEL	A	-40,617	ADMINISTRATIVE & GENERAL	5.00		0	45.26
45.32 CSM AND 901 DEPRECIATION	A	-632,778	CAP REL COSTS-BLDG & FIXT	1.00		9	45.32
45.33 AMORT OF DEPR EXP OF DEMOLISHED	A	68,111	CAP REL COSTS-BLDG & FIXT	1.00		9	45.33
45.35 MED VS BOOK DEP DIFF	A	5,313,112	CAP REL COSTS-BLDG & FIXT	1.00		9	45.35
45.36 MED VS BOOK DEPR DIFF	A	-15,603	CAP REL COSTS-MVBLE EQUIP	2.00		9	45.36
46.00 MAINFRAME SERVER EDITION-RECORD	A	195,000	CAP REL COSTS-MVBLE EQUIP	2.00		9	46.00
47.00 PT B NON PHY COST	A	-292,712	PHYSICAL THERAPY	66.00		0	47.00
47.01 PROFESSIONAL COMPONENT	A	-17,664	CORPORATE HEALTH	194.00		0	47.01
47.02 PROFESSIONAL COMPONENT	A	-232,082	OTHER NRCC	194.03		0	47.02
47.03 OFFSET INTERCOMPANY RENT	A	-182,600	ADMINISTRATIVE & GENERAL	5.00		0	47.03
47.04 LOSS ON EARLY ESTINGUISHMENT OF DEBT	A	12,642,472	CAP REL COSTS-BLDG & FIXT	1.00		11	47.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,440,482					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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet A-8-2

Date/Time Prepared:  
2/27/2019 4:58 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	598,068	598,068	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	1,026,511	0	1,026,511	211,500	8,760	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	541,770	0	541,770	211,500	8,760	3.00
4.00	50.00	OPERATING ROOM	60,770	60,770	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	41,678	0	41,678	271,900	225	5.00
6.00	56.01	ONCOLOGY	60,639	0	60,639	211,500	328	6.00
7.00	60.00	LABORATORY	493,470	21,277	472,193	260,300	2,552	7.00
8.00	69.00	ELECTROCARDIOLOGY	642,107	43,174	598,933	211,500	1,711	8.00
9.00	69.01	CARDIAC CATH LAB	17,770	17,770	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	4,533	4,533	0	0	0	10.00
12.00	91.00	EMERGENCY	1,264,000	28,000	1,236,000	211,500	19,520	12.00
200.00			4,751,316	773,592	3,977,724		41,856	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	890,740	44,537	0	0	0	2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	890,740	44,537	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	29,412	1,471	0	0	0	5.00
6.00	56.01	ONCOLOGY	33,352	1,668	0	0	0	6.00
7.00	60.00	LABORATORY	319,368	15,968	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	173,979	8,699	0	0	0	8.00
9.00	69.01	CARDIAC CATH LAB	0	0	0	0	0	9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	0	0	10.00
12.00	91.00	EMERGENCY	1,984,846	99,242	0	0	0	12.00
200.00			4,322,437	216,122	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	598,068		1.00
2.00	31.00	INTENSIVE CARE UNIT	0	890,740	135,771	135,771		2.00
3.00	35.00	NEONATAL INTENSIVE CARE UNIT	0	890,740	0	0		3.00
4.00	50.00	OPERATING ROOM	0	0	0	60,770		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	29,412	12,266	12,266		5.00
6.00	56.01	ONCOLOGY	0	33,352	27,287	27,287		6.00
7.00	60.00	LABORATORY	0	319,368	152,825	174,102		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	173,979	424,954	468,128		8.00
9.00	69.01	CARDIAC CATH LAB	0	0	0	17,770		9.00
10.00	76.97	CARDIAC REHABILITATION	0	0	0	4,533		10.00
12.00	91.00	EMERGENCY	0	1,984,846	0	28,000		12.00
200.00			0	4,322,437	753,103	1,526,695		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 4: 58 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	40,748,027	40,748,027			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	18,502,465		18,502,465		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	33,011,832	600,311	4,296	33,616,439	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	71,586,510	9,430,365	10,366,473	6,131,972	97,515,320
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	18,118,533	5,532,603	138,221	659,779	24,449,136
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	7,068,735	0	11,131	575,848	7,655,714
10.00 01000	DIETARY	1,525,144	488,879	65,791	292,363	2,372,177
11.00 01100	CAFETERIA	688,145	321,496	0	216,267	1,225,908
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	9,175,077	399,111	109,329	1,409,615	11,093,132
14.00 01400	CENTRAL SERVICES & SUPPLY	4,481,065	728,651	323,347	494,353	6,027,416
15.00 01500	PHARMACY	5,043,709	290,556	159,021	754,227	6,247,513
16.00 01600	MEDICAL RECORDS & LIBRARY	5,032,075	247,287	21,176	424,999	5,725,537
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	138,286	28,416	4,033	90,762	261,497
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	30,275,601	5,349,721	495,944	5,014,251	41,135,517
31.00 03100	INTENSIVE CARE UNIT	10,139,217	1,508,438	175,367	1,478,477	13,301,499
35.00 02060	NEONATAL INTENSIVE CARE UNIT	2,479,910	116,950	108,851	315,378	3,021,089
40.00 04000	SUBPROVIDER - I PF	7,661,586	998,248	86,810	1,073,768	9,820,412
41.00 04100	SUBPROVIDER - I RF	2,108,195	704,110	45,340	336,195	3,193,840
43.00 04300	NURSERY	2,010,598	237,130	0	302,062	2,549,790
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	18,101,633	3,678,363	2,281,669	2,156,002	26,217,667
52.00 05200	DELIVERY ROOM & LABOR ROOM	4,838,818	550,055	103,263	603,048	6,095,184
53.00 05300	ANESTHESIOLOGY	348,002	30,647	106,687	30,856	516,192
54.00 05400	RADIOLOGY-DIAGNOSTIC	19,990,295	2,008,472	1,587,144	2,544,808	26,130,719
54.01 05401	OFFSITE-DIAGNOSTIC SERVICES	2,512,522	0	403,338	300,734	3,216,594
56.01 03480	ONCOLOGY	11,955,056	995,958	67,149	253,593	13,271,756
60.00 06000	LABORATORY	16,370,395	791,999	184,702	1,249,527	18,596,623
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,943,548	54,600	25,320	81,303	3,104,771
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	2,816,518	185,700	63,846	383,798	3,449,862
66.00 06600	PHYSICAL THERAPY	8,927,386	576,416	86,548	1,265,097	10,855,447
66.01 06601	I P REHAB THERAPIES	2,563,664	0	0	0	2,563,664
69.00 06900	ELECTROCARDIOLOGY	5,895,754	315,391	442,901	759,947	7,413,993
69.01 03630	CARDIAC CATH LAB	2,295,881	140,141	552,267	323,515	3,311,804
69.02 03160	CARDIAC REHABILITATION	0	0	0	0	69.02
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	24,347,120	0	0	0	24,347,120
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	15,757,356	0	0	0	15,757,356
73.00 07300	DRUGS CHARGED TO PATIENTS	10,324,181	0	0	0	10,324,181
73.01 07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	1,778,379	0	2,688	0	1,781,067
76.97 07697	CARDIAC REHABILITATION	998,111	517,353	14,535	131,527	1,661,526
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LITHOTRIpsy	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001	OUTPATIENT TREATMENT CENTERS	3,586,058	1,268,197	194,675	336,864	5,385,794
90.02 09002	PARTIAL HOSPITALIZATION PROGRAM	1,799,834	284,979	0	281,043	2,365,856
91.00 09100	EMERGENCY	10,353,066	921,044	123,876	1,437,750	12,835,736
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	2,954,546	0	24,931	459,342	3,438,819
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00 10100	HOME HEALTH AGENCY	7,065,294	303,883	17,223	900,636	8,287,036
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	448,318,127	39,605,470	18,397,892	33,069,706	446,524,264

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	337,868	332,593	0	25,321	695,782 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	DAY SURGERY CENTER	1	0	0	0	1 192.01
192.02 19202	RESIDENTIAL TREATMENT CENTER	1,124,164	0	14,385	179,021	1,317,570 192.02
192.03 19203	MOBILE DENTAL CLINIC	301,358	0	52,559	40,049	393,966 192.03
192.04 19204	EMS CONTINUING EDUCATION	896,720	0	10,069	90,906	997,695 192.04
194.00 07950	CORPORATE HEALTH	138,788	159,750	10,511	20,030	329,079 194.00
194.01 07951	MARKETING/COMMUNICATION	407,349	118,360	0	15,341	541,050 194.01
194.02 07952	FOUNDATION	0	52,780	0	0	52,780 194.02
194.03 07953	OTHER NRCC	2,717,747	479,074	17,049	122,183	3,336,053 194.03
194.04 07954	OP PHARMACY	2,018,594	0	0	53,882	2,072,476 194.04
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118 through 201)	456,260,716	40,748,027	18,502,465	33,616,439	456,260,716 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	97,515,320				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0			6.00
7.00	00700	OPERATION OF PLANT	6,645,837	0	31,094,973		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	2,080,999	0	0	0	9,736,713
10.00	01000	DIETARY	644,812	0	603,606	0	189,006
11.00	01100	CAFETERIA	333,230	0	396,944	0	124,294
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	3,015,368	0	492,772	0	154,301
14.00	01400	CENTRAL SERVICES & SUPPLY	1,638,390	0	899,647	0	281,705
15.00	01500	PHARMACY	1,698,218	0	358,742	0	112,332
16.00	01600	MEDICAL RECORDS & LIBRARY	1,556,333	0	305,319	0	95,604
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	71,081	0	35,084	0	10,986
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	11,181,651	0	6,605,165	0	2,068,265
31.00	03100	INTENSIVE CARE UNIT	3,615,653	0	1,862,431	0	583,180
35.00	02060	NEONATAL INTENSIVE CARE UNIT	821,201	0	144,396	0	45,214
40.00	04000	SUBPROVIDER - I PF	2,669,414	0	1,232,511	0	385,934
41.00	04100	SUBPROVIDER - I RF	868,159	0	869,347	0	272,217
43.00	04300	NURSERY	693,092	0	292,778	0	91,677
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	7,126,565	0	4,541,582	0	1,422,097
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,656,811	0	679,139	0	212,658
53.00	05300	ANESTHESIOLOGY	140,313	0	37,839	0	11,848
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,102,930	0	2,479,810	0	776,498
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	874,344	0	0	0	0
56.01	03480	ONCOLOGY	3,607,569	0	1,229,684	0	385,049
60.00	06000	LABORATORY	5,054,990	0	977,861	0	306,196
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	843,948	0	67,414	0	21,109
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	937,752	0	229,279	0	71,794
66.00	06600	PHYSICAL THERAPY	2,950,760	0	711,686	0	222,849
66.01	06601	I P REHAB THERAPIES	696,863	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,015,294	0	389,405	0	121,934
69.01	03630	CARDIAC CATH LAB	900,224	0	173,029	0	54,180
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,618,107	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,283,212	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,806,350	0	0	0	0
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	484,135	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	451,641	0	638,763	0	200,015
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LI THOTRI PSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	1,463,983	0	1,565,810	0	490,299
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	643,094	0	351,856	0	110,176
91.00	09100	EMERGENCY	3,489,048	0	1,137,190	0	356,086
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	934,750	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	2,252,607	0	375,197	0	117,485
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,868,728	0	29,684,286	0	9,294,988
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	189,130	0	410,644	0	128,584
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0
192.02	19202	RESIDENTIAL TREATMENT CENTER	358,146	0	0	0	0
192.03	19203	MOBILE DENTAL CLINIC	107,089	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
192.04	19204	EMS CONTINUING EDUCATION	271,196	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	89,451	0	197,239	0	61,761	194.00
194.01	07951	MARKETING/COMMUNICATION	147,070	0	146,136	0	45,759	194.01
194.02	07952	FOUNDATION	14,347	0	65,167	0	20,405	194.02
194.03	07953	OTHER NRCC	906,816	0	591,501	0	185,216	194.03
194.04	07954	OP PHARMACY	563,347	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	97,515,320	0	31,094,973	0	9,736,713	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part I Date/Time Prepared: 2/27/2019 4:58 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	3,809,601					10.00
11.00	01100	CAFETERIA	0	2,080,376				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	94,541	0	14,850,114		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,485	0	0	8,906,643	14.00
15.00	01500	PHARMACY	0	50,635	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	41,990	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	5,958	0	70,411	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,732,231	448,140	0	5,296,321	0	30.00
31.00	03100	INTENSIVE CARE UNIT	161,982	107,912	0	1,275,347	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	23,139	0	273,470	0	35.00
40.00	04000	SUBPROVIDER - IPF	549,456	96,083	0	1,135,547	0	40.00
41.00	04100	SUBPROVIDER - IRF	235,168	31,839	0	376,286	0	41.00
43.00	04300	NURSERY	0	23,875	0	282,167	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	174,437	0	2,061,576	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	45,975	0	543,357	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,472	0	52,846	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	203,004	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	23,947	0	0	0	54.01
56.01	03480	ONCOLOGY	0	17,475	0	206,532	0	56.01
60.00	06000	LABORATORY	0	141,604	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,677	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	33,113	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	100,717	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	54,890	0	648,715	0	69.00
69.01	03630	CARDIAC CATH LAB	0	21,819	0	257,863	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	5,397,821	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,493,437	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	11,262	0	133,098	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	30,950	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	24,916	0	294,471	0	90.02
91.00	09100	EMERGENCY	0	124,053	0	1,466,114	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	40,275	0	475,993	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,678,837	2,044,183	0	14,850,114	8,891,258	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,958	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	130,764	14,655	0	0	459	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		10.00	11.00	12.00	13.00	14.00		
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	3,641	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	6,375	0	0	138	192.04
194.00	07950	CORPORATE HEALTH	0	1,670	0	0	138	194.00
194.01	07951	MARKETING/COMMUNICATION	0	1,265	0	0	0	194.01
194.02	07952	FOUNDATION	0	0	0	0	0	194.02
194.03	07953	OTHER NRCC	0	4,467	0	0	10,423	194.03
194.04	07954	OP PHARMACY	0	3,803	0	0	586	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,809,601	2,080,376	0	14,850,114	8,906,643	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part I Date/Time Prepared: 2/27/2019 4:58 pm	
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	8,467,440					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,724,783				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	570,390	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	182,427	0	0	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	39,776	0	0	0	35.00
40.00	04000	SUBPROVIDER - I PF	0	146,788	0	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	44,511	0	0	0	41.00
43.00	04300	NURSERY	0	38,705	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	640,443	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	58,949	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	55,480	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,780,631	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	214,659	0	0	0	54.01
56.01	03480	ONCOLOGY	3,935,319	142,217	0	0	0	56.01
60.00	06000	LABORATORY	0	836,134	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	73,355	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	142,545	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	189,292	0	0	0	66.00
66.01	06601	I P REHAB THERAPIES	0	33,444	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	248,040	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	242,965	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	659,341	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	334,289	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,940,310	281,788	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	31,179	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	15,842	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	58,515	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	8,109	0	0	0	90.02
91.00	09100	EMERGENCY	0	603,380	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	51,589	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	406	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,876,035	7,724,783	0	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	62	0	0	0	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
192.03	19203	MOBILE DENTAL CLINIC	4	0	0	0	0
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0
194.00	07950	CORPORATE HEALTH	0	0	0	0	0
194.01	07951	MARKETING/COMMUNICATION	0	0	0	0	0
194.02	07952	FOUNDATION	0	0	0	0	0
194.03	07953	OTHER NRCC	0	0	0	0	0
194.04	07954	OP PHARMACY	591,339	0	0	0	0
200.00		Cross Foot Adjustments					0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	8,467,440	7,724,783	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00 00500 ADMINISTRATIVE & GENERAL					5.00	
6.00 00600 MAINTENANCE & REPAIRS					6.00	
7.00 00700 OPERATION OF PLANT					7.00	
8.00 00800 LAUNDRY & LINEN SERVICE					8.00	
9.00 00900 HOUSEKEEPING					9.00	
10.00 01000 DIETARY					10.00	
11.00 01100 CAFETERIA					11.00	
12.00 01200 MAINTENANCE OF PERSONNEL					12.00	
13.00 01300 NURSING ADMINISTRATION					13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00	
15.00 01500 PHARMACY					15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00	
17.00 01700 SOCIAL SERVICE					17.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00	
20.00 02000 NURSING SCHOOL					20.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0				21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00	
23.00 02300 PARAMED PRGM-(SPECIFY)			455,017		23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	0	0	27,475	70,065,155	0 30.00	
31.00 03100 INTENSIVE CARE UNIT	0	0	15,424	21,105,855	0 31.00	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	4,368,285	0 35.00	
40.00 04000 SUBPROVIDER - I/PF	0	0	15,424	16,051,569	0 40.00	
41.00 04100 SUBPROVIDER - I/RF	0	0	0	5,891,367	0 41.00	
43.00 04300 NURSERY	0	0	0	3,972,084	0 43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	30,849	42,215,216	0 50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	18,798	9,310,871	0 52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	818,990	0 53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	38,473,592	0 54.00	
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0	0	0	4,329,544	0 54.01	
56.01 03480 ONCOLOGY	0	0	0	22,795,601	0 56.01	
60.00 06000 LABORATORY	0	0	0	25,913,408	0 60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	4,118,274	0 62.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30	
65.00 06500 RESPIRATORY THERAPY	0	0	0	4,864,345	0 65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	15,030,751	0 66.00	
66.01 06601 I/P REHAB THERAPIES	0	0	0	3,293,971	0 66.01	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	10,892,271	0 69.00	
69.01 03630 CARDIAC CATH LAB	0	0	0	4,961,884	0 69.01	
69.02 03160 CARDIAC REHABILITATION	0	0	0	0	0 69.02	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37,022,389	0 71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,868,294	0 72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	17,352,629	0 73.00	
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0 73.01	
74.00 07400 RENAL DIALYSIS	0	0	0	2,296,381	0 74.00	
76.97 07697 CARDIAC REHABILITATION	0	0	0	3,112,147	0 76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98	
76.99 07699 LI THOTRI PSY	0	0	0	0	0 76.99	
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001 OUTPATIENT TREATMENT CENTERS	0	0	0	8,995,351	0 90.01	
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	3,798,478	0 90.02	
91.00 09100 EMERGENCY	0	0	347,047	20,358,654	0 91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	4,941,426	0 92.01	
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910 CORF	0	0	0	0	0 99.10	
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20	
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30	
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40	
101.00 10100 HOME HEALTH AGENCY	0	0	0	11,032,731	0 101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE					113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	455,017	441,251,513	0 118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

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Cost Center Description	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV						
	21.00	22.00						
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	1,428,098	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	1	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	1,821,656	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	504,700	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	1,275,404	0	192.04
194.00	07950	CORPORATE HEALTH	0	0	0	679,338	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	0	0	881,280	0	194.01
194.02	07952	FOUNDATION	0	0	0	152,699	0	194.02
194.03	07953	OTHER NRCC	0	0	0	5,034,476	0	194.03
194.04	07954	OP PHARMACY	0	0	0	3,231,551	0	194.04
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	455,017	456,260,716	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part I Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
20.00	02000	NURSING SCHOOL	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	35.00
40.00	04000	SUBPROVIDER - I PF	40.00
41.00	04100	SUBPROVIDER - I RF	41.00
43.00	04300	NURSERY	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	54.01
56.01	03480	ONCOLOGY	56.01
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
66.01	06601	IP REHAB THERAPIES	66.01
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	03630	CARDIAC CATH LAB	69.01
69.02	03160	CARDIAC REHABILITATION	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	73.01
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIpsy	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.01	09001	OUTPATIENT TREATMENT CENTERS	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	90.02
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
101.00	10100	HOME HEALTH AGENCY	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	DAY SURGERY CENTER	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	192.02
192.03	19203	MOBILE DENTAL CLINIC	192.03
192.04	19204	EMS CONTINUING EDUCATION	192.04

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
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Cost Center Description		Total	
		26.00	
194.00	07950 CORPORATE HEALTH	679,338	194.00
194.01	07951 MARKETING/COMMUNICATION	881,280	194.01
194.02	07952 FOUNDATION	152,699	194.02
194.03	07953 OTHER NRCC	5,034,476	194.03
194.04	07954 OP PHARMACY	3,231,551	194.04
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118 through 201)	456,260,716	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	128,478	600,311	4,296	733,085	733,085 4.00
5.00 00500	ADMINISTRATIVE & GENERAL	8,684,053	9,430,365	10,366,473	28,480,891	133,796 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	136,306	5,532,603	138,221	5,807,130	14,386 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	668	0	11,131	11,799	12,556 9.00
10.00 01000	DIETARY	73,345	488,879	65,791	628,015	6,375 10.00
11.00 01100	CAFETERIA	0	321,496	0	321,496	4,716 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	15,753	399,111	109,329	524,193	30,736 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	465,049	728,651	323,347	1,517,047	10,779 14.00
15.00 01500	PHARMACY	24,218	290,556	159,021	473,795	16,446 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,076	247,287	21,176	269,539	9,267 16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0 17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0 22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	28,416	4,033	32,449	1,979 23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	151,507	5,349,721	495,944	5,997,172	109,334 30.00
31.00 03100	INTENSIVE CARE UNIT	3,568	1,508,438	175,367	1,687,373	32,238 31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,985	116,950	108,851	227,786	6,877 35.00
40.00 04000	SUBPROVIDER - I/PF	7,988	998,248	86,810	1,093,046	23,413 40.00
41.00 04100	SUBPROVIDER - I/RF	24,798	704,110	45,340	774,248	7,331 41.00
43.00 04300	NURSERY	0	237,130	0	237,130	6,586 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	180,335	3,678,363	2,281,669	6,140,367	47,011 50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	550,055	103,263	653,318	13,149 52.00
53.00 05300	ANESTHESIOLOGY	0	30,647	106,687	137,334	673 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	729,104	2,008,472	1,587,144	4,324,720	55,489 54.00
54.01 05401	OFFSITE-DIAGNOSTIC SERVICES	384,477	0	403,338	787,815	6,557 54.01
56.01 03480	ONCOLOGY	14,936	995,958	67,149	1,078,043	5,530 56.01
60.00 06000	LABORATORY	93,401	791,999	184,702	1,070,102	27,245 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	855	54,600	25,320	80,775	1,773 62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500	RESPIRATORY THERAPY	36,612	185,700	63,846	286,158	8,369 65.00
66.00 06600	PHYSICAL THERAPY	932,385	576,416	86,548	1,595,349	27,585 66.00
66.01 06601	I/P REHAB THERAPIES	0	0	0	0	0 66.01
69.00 06900	ELECTROCARDIOLOGY	317,562	315,391	442,901	1,075,854	16,570 69.00
69.01 03630	CARDIAC CATH LAB	66,274	140,141	552,267	758,682	7,054 69.01
69.02 03160	CARDIAC REHABILITATION	164,071	0	0	164,071	0 69.02
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
73.01 07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0 73.01
74.00 07400	RENAL DIALYSIS	600	0	2,688	3,288	0 74.00
76.97 07697	CARDIAC REHABILITATION	0	517,353	14,535	531,888	2,868 76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699	LITHOTRI PSY	0	0	0	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001	OUTPATIENT TREATMENT CENTERS	567,047	1,268,197	194,675	2,029,919	7,345 90.01
90.02 09002	PARTIAL HOSPITALIZATION PROGRAM	0	284,979	0	284,979	6,128 90.02
91.00 09100	EMERGENCY	354,829	921,044	123,876	1,399,749	31,350 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0	24,931	24,931	10,016 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	0 99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0 99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0 99.40
101.00 10100	HOME HEALTH AGENCY	5,441	303,883	17,223	326,547	19,638 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0 113.00
118.00 11800	SUBTOTALS (SUM OF LINES 1 through 117)	13,566,721	39,605,470	18,397,892	71,570,083	721,165 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	332,593	0	332,593	552 190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02 19202 RESIDENTIAL TREATMENT CENTER	853	0	14,385	15,238	3,903	192.02
192.03 19203 MOBILE DENTAL CLINIC	5,291	0	52,559	57,850	873	192.03
192.04 19204 EMS CONTINUING EDUCATION	0	0	10,069	10,069	1,982	192.04
194.00 07950 CORPORATE HEALTH	0	159,750	10,511	170,261	437	194.00
194.01 07951 MARKETING/COMMUNICATION	498	118,360	0	118,858	334	194.01
194.02 07952 FOUNDATION	0	52,780	0	52,780	0	194.02
194.03 07953 OTHER NRCC	0	479,074	17,049	496,123	2,664	194.03
194.04 07954 OP PHARMACY	21,170	0	0	21,170	1,175	194.04
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers				0		201.00
202.00 TOTAL (sum lines 118 through 201)	13,594,533	40,748,027	18,502,465	72,845,025	733,085	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,614,687					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,950,136	0	7,771,652			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0		8.00
9.00	00900	HOUSEKEEPING	610,643	0	0	0	634,998	9.00
10.00	01000	DIETARY	189,212	0	150,861	0	12,326	10.00
11.00	01100	CAFETERIA	97,782	0	99,209	0	8,106	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	884,821	0	123,160	0	10,063	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	480,765	0	224,851	0	18,372	14.00
15.00	01500	PHARMACY	498,320	0	89,661	0	7,326	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	456,686	0	76,309	0	6,235	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	20,858	0	8,769	0	716	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	3,281,171	0	1,650,850	0	134,886	30.00
31.00	03100	INTENSIVE CARE UNIT	1,060,967	0	465,482	0	38,033	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	240,971	0	36,089	0	2,949	35.00
40.00	04000	SUBPROVIDER - I PF	783,306	0	308,045	0	25,169	40.00
41.00	04100	SUBPROVIDER - I RF	254,750	0	217,278	0	17,753	41.00
43.00	04300	NURSERY	203,379	0	73,175	0	5,979	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	2,091,200	0	1,135,090	0	92,745	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	486,170	0	169,739	0	13,869	52.00
53.00	05300	ANESTHESIOLOGY	41,173	0	9,457	0	773	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,084,265	0	619,786	0	50,641	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	256,565	0	0	0	0	54.01
56.01	03480	ONCOLOGY	1,058,595	0	307,338	0	25,112	56.01
60.00	06000	LABORATORY	1,483,322	0	244,400	0	19,969	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	247,646	0	16,849	0	1,377	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	275,171	0	57,304	0	4,682	65.00
66.00	06600	PHYSICAL THERAPY	865,863	0	177,874	0	14,534	66.00
66.01	06601	I P REHAB THERAPIES	204,486	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	591,362	0	97,325	0	7,952	69.00
69.01	03630	CARDIAC CATH LAB	264,159	0	43,245	0	3,533	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,941,999	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,256,854	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	823,488	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	142,063	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	132,528	0	159,648	0	13,044	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	429,587	0	391,347	0	31,976	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	188,708	0	87,940	0	7,185	90.02
91.00	09100	EMERGENCY	1,023,817	0	284,221	0	23,223	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	274,291	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	660,999	0	93,774	0	7,662	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,838,078	0	7,419,076	0	606,190	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	55,498	0	102,633	0	8,386	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	105,093	0	0	0	0	192.02
192.03	19203	MOBILE DENTAL CLINIC	31,424	0	0	0	0	192.03

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
192.04	19204	EMS CONTINUING EDUCATION	79,579	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	26,248	0	49,297	0	4,028	194.00
194.01	07951	MARKETING/COMMUNICATION	43,156	0	36,524	0	2,984	194.01
194.02	07952	FOUNDATION	4,210	0	16,287	0	1,331	194.02
194.03	07953	OTHER NRCC	266,094	0	147,835	0	12,079	194.03
194.04	07954	OP PHARMACY	165,307	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,614,687	0	7,771,652	0	634,998	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet B Part II Date/Time Prepared: 2/27/2019 4:58 pm	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	986,789					10.00
11.00	01100	CAFETERIA	0	531,309				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	24,145	0	1,597,118		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	15,192	0	0	2,267,006	14.00
15.00	01500	PHARMACY	0	12,932	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,724	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	1,522	0	7,573	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	707,721	114,448	0	569,615	0	30.00
31.00	03100	INTENSIVE CARE UNIT	41,958	27,560	0	137,162	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	5,910	0	29,411	0	35.00
40.00	04000	SUBPROVIDER - IPF	142,324	24,539	0	122,127	0	40.00
41.00	04100	SUBPROVIDER - IRF	60,915	8,131	0	40,469	0	41.00
43.00	04300	NURSERY	0	6,098	0	30,347	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	44,550	0	221,721	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,742	0	58,438	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,142	0	5,684	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	51,846	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	6,116	0	0	0	54.01
56.01	03480	ONCOLOGY	0	4,463	0	22,212	0	56.01
60.00	06000	LABORATORY	0	36,165	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,961	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	8,457	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	25,722	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	14,018	0	69,769	0	69.00
69.01	03630	CARDIAC CATH LAB	0	5,572	0	27,733	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,373,902	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	889,188	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	2,876	0	14,315	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	7,904	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	6,363	0	31,670	0	90.02
91.00	09100	EMERGENCY	0	31,682	0	157,679	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	10,286	0	51,193	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	952,918	522,066	0	1,597,118	2,263,090	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,011	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	33,871	3,743	0	0	117	192.02

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 4:58 pm			
Cost Center Description		DI ETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
192.03	19203 MOBILE DENTAL CLINIC	0	0	0	0	927	192.03
192.04	19204 EMS CONTINUING EDUCATION	0	1,628	0	0	35	192.04
194.00	07950 CORPORATE HEALTH	0	426	0	0	35	194.00
194.01	07951 MARKETING/COMMUNICATION	0	323	0	0	0	194.01
194.02	07952 FOUNDATION	0	0	0	0	0	194.02
194.03	07953 OTHER NRCC	0	1,141	0	0	2,653	194.03
194.04	07954 OP PHARMACY	0	971	0	0	149	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	986,789	531,309	0	1,597,118	2,267,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 4:58 pm		
Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL
			15.00	16.00	17.00	19.00	20.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	1,098,480				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	828,760			16.00
17.00	01700	SOCIAL SERVICE	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	61,207	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	19,576	0		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	4,268	0		35.00
40.00	04000	SUBPROVIDER - IPF	0	15,752	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	4,776	0		41.00
43.00	04300	NURSERY	0	4,153	0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	68,725	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,326	0		52.00
53.00	05300	ANESTHESIOLOGY	0	5,954	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	190,902	0		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	23,035	0		54.01
56.01	03480	ONCOLOGY	510,524	15,261	0		56.01
60.00	06000	LABORATORY	0	89,724	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,872	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	15,296	0		65.00
66.00	06600	PHYSICAL THERAPY	0	20,313	0		66.00
66.01	06601	IP REHAB THERAPIES	0	3,589	0		66.01
69.00	06900	ELECTROCARDIOLOGY	0	26,617	0		69.00
69.01	03630	CARDIAC CATH LAB	0	26,072	0		69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	70,753	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	35,872	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	511,180	30,238	0		73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	3,346	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	1,700	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0		76.98
76.99	07699	LITHOTRIpsy	0	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	6,279	0		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	870	0		90.02
91.00	09100	EMERGENCY	0	64,748	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	5,536	0		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	10100	HOME HEALTH AGENCY	53	0	0		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,021,757	828,760	0	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
192.01	19201	DAY SURGERY CENTER	0	0	0		192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	8	0	0		192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
192.03	19203 MOBILE DENTAL CLINIC	1	0	0			192.03
192.04	19204 EMS CONTINUING EDUCATION	0	0	0			192.04
194.00	07950 CORPORATE HEALTH	0	0	0			194.00
194.01	07951 MARKETING/COMMUNICATION	0	0	0			194.01
194.02	07952 FOUNDATION	0	0	0			194.02
194.03	07953 OTHER NRCC	0	0	0			194.03
194.04	07954 OP PHARMACY	76,714	0	0			194.04
200.00	Cross Foot Adjustments				0		0 200.00
201.00	Negative Cost Centers	0	0	0	0		0 201.00
202.00	TOTAL (sum lines 118 through 201)	1,098,480	828,760	0	0		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
	21.00	22.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00 00500 ADMINISTRATIVE & GENERAL					5.00	
6.00 00600 MAINTENANCE & REPAIRS					6.00	
7.00 00700 OPERATION OF PLANT					7.00	
8.00 00800 LAUNDRY & LINEN SERVICE					8.00	
9.00 00900 HOUSEKEEPING					9.00	
10.00 01000 DIETARY					10.00	
11.00 01100 CAFETERIA					11.00	
12.00 01200 MAINTENANCE OF PERSONNEL					12.00	
13.00 01300 NURSING ADMINISTRATION					13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00	
15.00 01500 PHARMACY					15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00	
17.00 01700 SOCIAL SERVICE					17.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00	
20.00 02000 NURSING SCHOOL					20.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0				21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0			22.00	
23.00 02300 PARAMED PRGM-(SPECIFY)			73,866		23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS				12,626,404	0 30.00	
31.00 03100 INTENSIVE CARE UNIT				3,510,349	0 31.00	
35.00 02060 NEONATAL INTENSIVE CARE UNIT				554,261	0 35.00	
40.00 04000 SUBPROVIDER - I PF				2,537,721	0 40.00	
41.00 04100 SUBPROVIDER - I RF				1,385,651	0 41.00	
43.00 04300 NURSERY				566,847	0 43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM				9,841,409	0 50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM				1,412,751	0 52.00	
53.00 05300 ANESTHESIOLOGY				202,190	0 53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC				7,377,649	0 54.00	
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES				1,080,088	0 54.01	
56.01 03480 ONCOLOGY				3,027,078	0 56.01	
60.00 06000 LABORATORY				2,970,927	0 60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				358,253	0 62.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS				0	0 62.30	
65.00 06500 RESPIRATORY THERAPY				655,437	0 65.00	
66.00 06600 PHYSICAL THERAPY				2,727,240	0 66.00	
66.01 06601 IP REHAB THERAPIES				208,075	0 66.01	
69.00 06900 ELECTROCARDIOLOGY				1,899,467	0 69.00	
69.01 03630 CARDIAC CATH LAB				1,136,050	0 69.01	
69.02 03160 CARDIAC REHABILITATION				164,071	0 69.02	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				3,386,654	0 71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS				2,181,914	0 72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS				1,364,906	0 73.00	
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS				0	0 73.01	
74.00 07400 RENAL DIALYSIS				148,697	0 74.00	
76.97 07697 CARDIAC REHABILITATION				858,867	0 76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY				0	0 76.98	
76.99 07699 LI THOTRI PSY				0	0 76.99	
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001 OUTPATIENT TREATMENT CENTERS				2,904,357	0 90.01	
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM				613,843	0 90.02	
91.00 09100 EMERGENCY				3,016,469	0 91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)				376,253	0 92.01	
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910 CORF				0	0 99.10	
99.20 09920 OUTPATIENT PHYSICAL THERAPY				0	0 99.20	
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY				0	0 99.30	
99.40 09940 OUTPATIENT SPEECH PATHOLOGY				0	0 99.40	
101.00 10100 HOME HEALTH AGENCY				1,108,673	0 101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE					113.00	
118.00						
	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	70,202,551	0 118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		500,673	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	0
192.01	19201	DAY SURGERY CENTER		0	0
192.02	19202	RESIDENTIAL TREATMENT CENTER		161,973	0
192.03	19203	MOBILE DENTAL CLINIC		91,075	0
192.04	19204	EMS CONTINUING EDUCATION		93,293	0
194.00	07950	CORPORATE HEALTH		250,732	0
194.01	07951	MARKETING/COMMUNICATION		202,179	0
194.02	07952	FOUNDATION		74,608	0
194.03	07953	OTHER NRCC		928,589	0
194.04	07954	OP PHARMACY		265,486	0
200.00		Cross Foot Adjustments	0	73,866	0
201.00		Negative Cost Centers	0	0	0
202.00		TOTAL (sum lines 118 through 201)	0	72,845,025	0

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Total		
		26.00		
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	12,626,404	30.00
31.00	03100	INTENSIVE CARE UNIT	3,510,349	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	554,261	35.00
40.00	04000	SUBPROVIDER - I PF	2,537,721	40.00
41.00	04100	SUBPROVIDER - I RF	1,385,651	41.00
43.00	04300	NURSERY	566,847	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	9,841,409	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,751	52.00
53.00	05300	ANESTHESIOLOGY	202,190	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,377,649	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,080,088	54.01
56.01	03480	ONCOLOGY	3,027,078	56.01
60.00	06000	LABORATORY	2,970,927	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	358,253	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	655,437	65.00
66.00	06600	PHYSICAL THERAPY	2,727,240	66.00
66.01	06601	IP REHAB THERAPIES	208,075	66.01
69.00	06900	ELECTROCARDIOLOGY	1,899,467	69.00
69.01	03630	CARDIAC CATH LAB	1,136,050	69.01
69.02	03160	CARDIAC REHABILITATION	164,071	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,386,654	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,181,914	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,364,906	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	73.01
74.00	07400	RENAL DIALYSIS	148,697	74.00
76.97	07697	CARDIAC REHABILITATION	858,867	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIpsy	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	09001	OUTPATIENT TREATMENT CENTERS	2,904,357	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	613,843	90.02
91.00	09100	EMERGENCY	3,016,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	376,253	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,108,673	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	70,202,551	118.00
<b>NONREIMBURSABLE COST CENTERS</b>				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	500,673	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	DAY SURGERY CENTER	0	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	161,973	192.02
192.03	19203	MOBILE DENTAL CLINIC	91,075	192.03
192.04	19204	EMS CONTINUING EDUCATION	93,293	192.04

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet B Part II Date/Time Prepared: 2/27/2019 4:58 pm
Cost Center Description		Total		
		26.00		
194.00	07950 CORPORATE HEALTH	250,732		194.00
194.01	07951 MARKETING/COMMUNICATION	202,179		194.01
194.02	07952 FOUNDATION	74,608		194.02
194.03	07953 OTHER NRCC	928,589		194.03
194.04	07954 OP PHARMACY	265,486		194.04
200.00	Cross Foot Adjustments	73,866		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118 through 201)	72,845,025		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00 00100	CAP REL COSTS-BLDG & FIXT	694,055					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		17,932,694				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	10,225	4,164	192,235,623			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	160,626	10,047,246	35,065,686	-97,515,320	358,745,396	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	94,236	133,965	3,772,946	0	24,449,136	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	10,788	3,292,989	0	7,655,714	9.00
10.00 01000	DIETARY	8,327	63,765	1,671,877	0	2,372,177	10.00
11.00 01100	CAFETERIA	5,476	0	1,236,721	0	1,225,908	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	6,798	105,962	8,060,885	0	11,093,132	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	12,411	313,390	2,826,960	0	6,027,416	14.00
15.00 01500	PHARMACY	4,949	154,124	4,313,046	0	6,247,513	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,212	20,524	2,430,359	0	5,725,537	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00 02300	PARAMED ED PRGM-(SPECIFY)	484	3,909	519,023	0	261,497	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00 03000	ADULTS & PEDIATRICS	91,121	480,672	28,674,001	0	41,135,517	30.00
31.00 03100	INTENSIVE CARE UNIT	25,693	169,967	8,454,671	0	13,301,499	31.00
35.00 02060	NEONATAL INTENSIVE CARE UNIT	1,992	105,499	1,803,491	0	3,021,089	35.00
40.00 04000	SUBPROVIDER - I/PF	17,003	84,137	6,140,343	0	9,820,412	40.00
41.00 04100	SUBPROVIDER - I/RF	11,993	43,944	1,922,531	0	3,193,840	41.00
43.00 04300	NURSERY	4,039	0	1,727,344	0	2,549,790	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00 05000	OPERATING ROOM	62,653	2,211,406	12,329,097	0	26,217,667	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	9,369	100,083	3,448,528	0	6,095,184	52.00
53.00 05300	ANESTHESIOLOGY	522	103,402	176,449	0	516,192	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	34,210	1,538,269	14,552,486	0	26,130,719	54.00
54.01 05401	OFFSITE-DIAGNOSTIC SERVICES	0	390,917	1,719,745	0	3,216,594	54.01
56.01 03480	ONCOLOGY	16,964	65,081	1,450,171	0	13,271,756	56.01
60.00 06000	LABORATORY	13,490	179,014	7,145,422	0	18,596,623	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	930	24,540	464,930	0	3,104,771	62.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	3,163	61,880	2,194,750	0	3,449,862	65.00
66.00 06600	PHYSICAL THERAPY	9,818	83,883	7,234,461	0	10,855,447	66.00
66.01 06601	I/P REHAB THERAPIES	0	0	0	0	2,563,664	66.01
69.00 06900	ELECTROCARDIOLOGY	5,372	429,262	4,345,757	0	7,413,993	69.00
69.01 03630	CARDIAC CATH LAB	2,387	535,260	1,850,021	0	3,311,804	69.01
69.02 03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	24,347,120	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,757,356	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,324,181	73.00
73.01 07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	0	2,605	0	0	1,781,067	74.00
76.97 07697	CARDIAC REHABILITATION	8,812	14,087	752,137	0	1,661,526	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699	LITHOTRIPSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01 09001	OUTPATIENT TREATMENT CENTERS	21,601	188,680	1,926,359	0	5,385,794	90.01
90.02 09002	PARTIAL HOSPITALIZATION PROGRAM	4,854	0	1,607,145	0	2,365,856	90.02
91.00 09100	EMERGENCY	15,688	120,061	8,221,774	0	12,835,736	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01 09201	OBSERVATION BEDS (DISTINCT PART)	0	24,163	2,626,748	0	3,438,819	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 09910	CORF	0	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 10100	HOME HEALTH AGENCY	5,176	16,693	5,150,289	0	8,287,036	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00 11300	INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	674,594	17,831,342	189,109,142	-97,515,320	349,008,944	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1

Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)			
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00					4.00	5A
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,665	0	144,799	0	695,782	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	DAY SURGERY CENTER	0	0	0	0	1	192.01
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	13,942	1,023,730	0	1,317,570	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	50,940	229,019	0	393,966	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	9,759	519,844	0	997,695	192.04
194.00	07950	CORPORATE HEALTH	2,721	10,187	114,539	0	329,079	194.00
194.01	07951	MARKETING/COMMUNICATION	2,016	0	87,725	0	541,050	194.01
194.02	07952	FOUNDATION	899	0	0	0	52,780	194.02
194.03	07953	OTHER NRCC	8,160	16,524	698,701	0	3,336,053	194.03
194.04	07954	OP PHARMACY	0	0	308,124	0	2,072,476	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	40,748,027	18,502,465	33,616,439		97,515,320	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	58.710083	1.031773	0.174871		0.271823	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			733,085		28,614,687	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003813		0.079763	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: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1

Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	428,968			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00
9.00	00900	HOUSEKEEPING	0	0	0	428,968	9.00
10.00	01000	DIETARY	0	8,327	0	8,327	287,022
11.00	01100	CAFETERIA	0	5,476	0	5,476	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	6,798	0	6,798	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,411	0	12,411	0
15.00	01500	PHARMACY	0	4,949	0	4,949	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,212	0	4,212	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	484	0	484	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	0	91,121	0	91,121	205,851
31.00	03100	INTENSIVE CARE UNIT	0	25,693	0	25,693	12,204
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	1,992	0	1,992	0
40.00	04000	SUBPROVIDER - I PF	0	17,003	0	17,003	41,397
41.00	04100	SUBPROVIDER - I RF	0	11,993	0	11,993	17,718
43.00	04300	NURSERY	0	4,039	0	4,039	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	62,653	0	62,653	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,369	0	9,369	0
53.00	05300	ANESTHESIOLOGY	0	522	0	522	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,210	0	34,210	0
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0
56.01	03480	ONCOLOGY	0	16,964	0	16,964	0
60.00	06000	LABORATORY	0	13,490	0	13,490	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	930	0	930	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	3,163	0	3,163	0
66.00	06600	PHYSICAL THERAPY	0	9,818	0	9,818	0
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	5,372	0	5,372	0
69.01	03630	CARDIAC CATH LAB	0	2,387	0	2,387	0
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	8,812	0	8,812	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	21,601	0	21,601	0
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	4,854	0	4,854	0
91.00	09100	EMERGENCY	0	15,688	0	15,688	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	5,176	0	5,176	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	409,507	0	409,507	277,170
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,665	0	5,665	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.01	19201	DAY SURGERY CENTER	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1

Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
192.02	19202	RESIDENTIAL TREATMENT CENTER	0	0	0	0	9,852	192.02
192.03	19203	MOBILE DENTAL CLINIC	0	0	0	0	0	192.03
192.04	19204	EMS CONTINUING EDUCATION	0	0	0	0	0	192.04
194.00	07950	CORPORATE HEALTH	0	2,721	0	2,721	0	194.00
194.01	07951	MARKETING/COMMUNICATION	0	2,016	0	2,016	0	194.01
194.02	07952	FOUNDATION	0	899	0	899	0	194.02
194.03	07953	OTHER NRCC	0	8,160	0	8,160	0	194.03
194.04	07954	OP PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	31,094,973	0	9,736,713	3,809,601	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	72.487862	0.000000	22.697994	13.272854	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	7,771,652	0	634,998	986,789	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	18.117090	0.000000	1.480292	3.438026	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: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1

Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTE'S NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUISTION)	
		11.00	12.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	4,042,569					11.00
12.00	01200		0				12.00
13.00	01300	183,711	0	2,441,661			13.00
14.00	01400	115,590	0	0	40,173,872		14.00
15.00	01500	98,394	0	0	0	22,185,928	15.00
16.00	01600	81,594	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	11,577	0	11,577	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	870,823	0	870,823	0	0	30.00
31.00	03100	209,693	0	209,693	0	0	31.00
35.00	02060	44,964	0	44,964	0	0	35.00
40.00	04000	186,707	0	186,707	0	0	40.00
41.00	04100	61,869	0	61,869	0	0	41.00
43.00	04300	46,394	0	46,394	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	338,965	0	338,965	0	0	50.00
52.00	05200	89,339	0	89,339	0	0	52.00
53.00	05300	8,689	0	8,689	0	0	53.00
54.00	05400	394,476	0	0	0	0	54.00
54.01	05401	46,533	0	0	0	0	54.01
56.01	03480	33,958	0	33,958	0	10,311,113	56.01
60.00	06000	275,164	0	0	0	0	60.00
62.00	06200	14,918	0	0	0	0	62.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	64,345	0	0	0	0	65.00
66.00	06600	195,712	0	0	0	0	66.00
66.01	06601	0	0	0	0	0	66.01
69.00	06900	106,662	0	106,662	0	0	69.00
69.01	03630	42,398	0	42,398	0	0	69.01
69.02	03160	0	0	0	0	0	69.02
71.00	07100	0	0	0	24,347,120	0	71.00
72.00	07200	0	0	0	15,757,356	0	72.00
73.00	07300	0	0	0	0	10,324,181	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	0	0	0	74.00
76.97	07697	21,884	0	21,884	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	60,141	0	0	0	0	90.01
90.02	09002	48,417	0	48,417	0	0	90.02
91.00	09100	241,059	0	241,059	0	0	91.00
92.00	09200						92.00
92.01	09201	78,263	0	78,263	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40
101.00	10100	0	0	0	0	1,065	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300						113.00
118.00		3,972,239	0	2,441,661	40,104,476	20,636,359	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	7,691	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1

Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (FTE'S NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUI STION)	
		11.00	12.00	13.00	14.00	15.00	
192.01	19201 DAY SURGERY CENTER	0	0	0	0	0	192.01
192.02	19202 RESIDENTIAL TREATMENT CENTER	28,477	0	0	2,072	162	192.02
192.03	19203 MOBILE DENTAL CLINIC	0	0	0	16,422	11	192.03
192.04	19204 EMS CONTINUING EDUCATION	12,387	0	0	622	0	192.04
194.00	07950 CORPORATE HEALTH	3,245	0	0	622	0	194.00
194.01	07951 MARKETING/COMMUNICATION	2,459	0	0	0	0	194.01
194.02	07952 FOUNDATION	0	0	0	0	0	194.02
194.03	07953 OTHER NRCC	8,681	0	0	47,015	0	194.03
194.04	07954 OP PHARMACY	7,390	0	0	2,643	1,549,396	194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,080,376	0	14,850,114	8,906,643	8,467,440	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.514617	0.000000	6.081972	0.221702	0.381658	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	531,309	0	1,597,118	2,267,006	1,098,480	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.131429	0.000000	0.654111	0.056430	0.049512	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: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,786,605,000					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	131,912,639	0	0	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	42,189,331	0	0	0	0	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	9,198,775	0	0	0	0	35.00
40.00 04000 SUBPROVIDER - I/PF	33,947,359	0	0	0	0	40.00
41.00 04100 SUBPROVIDER - I/RF	10,293,847	0	0	0	0	41.00
43.00 04300 NURSERY	8,951,163	0	0	0	0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	148,113,516	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	13,633,093	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	12,830,824	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	411,916,877	0	0	0	0	54.00
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	49,643,641	0	0	0	0	54.01
56.01 03480 ONCOLOGY	32,890,237	0	0	0	0	56.01
60.00 06000 LABORATORY	193,370,549	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16,964,664	0	0	0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	32,965,951	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	43,777,041	0	0	0	0	66.00
66.01 06601 I/P REHAB THERAPIES	7,734,471	0	0	0	0	66.01
69.00 06900 ELECTROCARDIOLOGY	57,363,508	0	0	0	0	69.00
69.01 03630 CARDIAC CATH LAB	56,189,854	0	0	0	0	69.01
69.02 03160 CARDIAC REHABILITATION	0	0	0	0	0	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	152,484,126	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	77,310,153	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	65,168,419	0	0	0	0	73.00
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	7,210,679	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	3,663,625	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001 OUTPATIENT TREATMENT CENTERS	13,532,558	0	0	0	0	90.01
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	1,875,263	0	0	0	0	90.02
91.00 09100 EMERGENCY	139,542,089	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	11,930,748	0	0	0	0	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910 CORF	0	0	0	0	0	99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00 11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,786,605,000	0	0	0	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	
	16.00	17.00	19.00	20.00	21.00	
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	DAY SURGERY CENTER	0	0	0	0	0 192.01
192.02 19202	RESIDENTIAL TREATMENT CENTER	0	0	0	0	0 192.02
192.03 19203	MOBILE DENTAL CLINIC	0	0	0	0	0 192.03
192.04 19204	EMS CONTINUING EDUCATION	0	0	0	0	0 192.04
194.00 07950	CORPORATE HEALTH	0	0	0	0	0 194.00
194.01 07951	MARKETING/COMMUNICATION	0	0	0	0	0 194.01
194.02 07952	FOUNDATION	0	0	0	0	0 194.02
194.03 07953	OTHER NRCC	0	0	0	0	0 194.03
194.04 07954	OP PHARMACY	0	0	0	0	0 194.04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7,724,783	0	0	0	0 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.004324	0.000000	0.000000	0.000000	0.000000 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	828,760	0	0	0	0 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000464	0.000000	0.000000	0.000000	0.000000 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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)		
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
	22.00	23.00		
<b>GENERAL SERVICE COST CENTERS</b>				
1.00 00100 CAP REL COSTS-BLDG & FIXT			1.00	
2.00 00200 CAP REL COSTS-MVBLE EQUIP			2.00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			4.00	
5.00 00500 ADMINISTRATIVE & GENERAL			5.00	
6.00 00600 MAINTENANCE & REPAIRS			6.00	
7.00 00700 OPERATION OF PLANT			7.00	
8.00 00800 LAUNDRY & LINEN SERVICE			8.00	
9.00 00900 HOUSEKEEPING			9.00	
10.00 01000 DIETARY			10.00	
11.00 01100 CAFETERIA			11.00	
12.00 01200 MAINTENANCE OF PERSONNEL			12.00	
13.00 01300 NURSING ADMINISTRATION			13.00	
14.00 01400 CENTRAL SERVICES & SUPPLY			14.00	
15.00 01500 PHARMACY			15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY			16.00	
17.00 01700 SOCIAL SERVICE			17.00	
19.00 01900 NONPHYSICIAN ANESTHETISTS			19.00	
20.00 02000 NURSING SCHOOL			20.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	6,608	22.00	
23.00 02300 PARAMED ED PRGM-(SPECIFY)			23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000 ADULTS & PEDIATRICS	0	399	30.00	
31.00 03100 INTENSIVE CARE UNIT	0	224	31.00	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	35.00	
40.00 04000 SUBPROVIDER - I PF	0	224	40.00	
41.00 04100 SUBPROVIDER - I RF	0	0	41.00	
43.00 04300 NURSERY	0	0	43.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	448	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	273	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00	
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0	0	54.01	
56.01 03480 ONCOLOGY	0	0	56.01	
60.00 06000 LABORATORY	0	0	60.00	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30	
65.00 06500 RESPIRATORY THERAPY	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	66.00	
66.01 06601 I P REHAB THERAPIES	0	0	66.01	
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00	
69.01 03630 CARDIAC CATH LAB	0	0	69.01	
69.02 03160 CARDIAC REHABILITATION	0	0	69.02	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00	
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01	
74.00 07400 RENAL DIALYSIS	0	0	74.00	
76.97 07697 CARDIAC REHABILITATION	0	0	76.97	
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98	
76.99 07699 LI THOTRI PSY	0	0	76.99	
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01 09001 OUTPATIENT TREATMENT CENTERS	0	0	90.01	
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	0	0	90.02	
91.00 09100 EMERGENCY	0	5,040	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01	
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10 09910 CORF	0	0	99.10	
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	99.20	
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30	
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	99.40	
101.00 10100 HOME HEALTH AGENCY	0	0	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>				
113.00 11300 INTEREST EXPENSE			113.00	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6,608	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet B-1

Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description	INTERNS & RESIDENTS	PARAMETERED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	22.00		
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01 19201 DAY SURGERY CENTER	0	0	192.01
192.02 19202 RESIDENTIAL TREATMENT CENTER	0	0	192.02
192.03 19203 MOBILE DENTAL CLINIC	0	0	192.03
192.04 19204 EMS CONTINUING EDUCATION	0	0	192.04
194.00 07950 CORPORATE HEALTH	0	0	194.00
194.01 07951 MARKETING/COMMUNICATION	0	0	194.01
194.02 07952 FOUNDATION	0	0	194.02
194.03 07953 OTHER NRCC	0	0	194.03
194.04 07954 OP PHARMACY	0	0	194.04
200.00 Cross Foot Adjustments			200.00
201.00 Negative Cost Centers			201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	455,017	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000000	68.858505	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	73,866	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	0.000000	11.178269	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: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	70,065,155	70,065,155	0	70,065,155	30.00
31.00	03100 INTENSIVE CARE UNIT	21,105,855	21,105,855	135,771	21,241,626	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4,368,285	4,368,285	0	4,368,285	35.00
40.00	04000 SUBPROVIDER - I/PF	16,051,569	16,051,569	0	16,051,569	40.00
41.00	04100 SUBPROVIDER - I/RF	5,891,367	5,891,367	0	5,891,367	41.00
43.00	04300 NURSERY	3,972,084	3,972,084	0	3,972,084	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	42,215,216	42,215,216	0	42,215,216	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,310,871	9,310,871	0	9,310,871	52.00
53.00	05300 ANESTHESIOLOGY	818,990	818,990	0	818,990	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	38,473,592	38,473,592	12,266	38,485,858	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	4,329,544	4,329,544	0	4,329,544	54.01
56.01	03480 ONCOLOGY	22,795,601	22,795,601	27,287	22,822,888	56.01
60.00	06000 LABORATORY	25,913,408	25,913,408	152,825	26,066,233	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	4,118,274	4,118,274	0	4,118,274	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	4,864,345	4,864,345	0	4,864,345	65.00
66.00	06600 PHYSICAL THERAPY	15,030,751	15,030,751	0	15,030,751	66.00
66.01	06601 IP REHAB THERAPIES	3,293,971	3,293,971	0	3,293,971	66.01
69.00	06900 ELECTROCARDIOLOGY	10,892,271	10,892,271	424,954	11,317,225	69.00
69.01	03630 CARDIAC CATH LAB	4,961,884	4,961,884	0	4,961,884	69.01
69.02	03160 CARDIAC REHABILITATION	0	0	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37,022,389	37,022,389	0	37,022,389	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	23,868,294	23,868,294	0	23,868,294	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17,352,629	17,352,629	0	17,352,629	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	2,296,381	2,296,381	0	2,296,381	74.00
76.97	07697 CARDIAC REHABILITATION	3,112,147	3,112,147	0	3,112,147	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	09001 OUTPATIENT TREATMENT CENTERS	8,995,351	8,995,351	0	8,995,351	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	3,798,478	3,798,478	0	3,798,478	90.02
91.00	09100 EMERGENCY	20,358,654	20,358,654	0	20,358,654	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,417,510	2,417,510	0	2,417,510	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	4,941,426	4,941,426	0	4,941,426	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100 HOME HEALTH AGENCY	11,032,731	11,032,731	0	11,032,731	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	443,669,023	443,669,023	753,103	444,422,126	200.00
201.00	Less Observation Beds	2,417,510	2,417,510		2,417,510	201.00
202.00	Total (see instructions)	441,251,513	441,251,513	753,103	442,004,616	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Title XVIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00	9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	129,727,539		129,727,539		30.00
31.00	03100	INTENSIVE CARE UNIT	42,189,331		42,189,331		31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	9,198,775		9,198,775		35.00
40.00	04000	SUBPROVIDER - I/PF	33,947,359		33,947,359		40.00
41.00	04100	SUBPROVIDER - I/RF	10,293,847		10,293,847		41.00
43.00	04300	NURSERY	8,951,163		8,951,163		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	55,309,837	92,803,679	148,113,516	0.285019	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	12,685,657	947,436	13,633,093	0.682961	52.00
53.00	05300	ANESTHESIOLOGY	6,447,193	6,383,631	12,830,824	0.063830	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	104,661,194	307,255,683	411,916,877	0.093401	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	352,922	49,290,719	49,643,641	0.087212	54.01
56.01	03480	ONCOLOGY	107,272	32,782,965	32,890,237	0.693081	56.01
60.00	06000	LABORATORY	83,174,055	110,196,494	193,370,549	0.134009	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	12,529,893	4,434,771	16,964,664	0.242756	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	30,568,066	2,397,885	32,965,951	0.147557	65.00
66.00	06600	PHYSICAL THERAPY	9,387,768	34,389,273	43,777,041	0.343348	66.00
66.01	06601	I/P REHAB THERAPIES	7,734,471	0	7,734,471	0.425882	66.01
69.00	06900	ELECTROCARDIOLOGY	12,557,460	44,806,048	57,363,508	0.189882	69.00
69.01	03630	CARDIAC CATH LAB	23,875,888	32,313,966	56,189,854	0.088306	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,149,841	69,334,285	152,484,126	0.242795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,210,949	31,099,204	77,310,153	0.308734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	53,480,997	11,687,422	65,168,419	0.266274	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	6,591,391	619,288	7,210,679	0.318469	74.00
76.97	07697	CARDIAC REHABILITATION	3,640	3,659,985	3,663,625	0.849472	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	43,821	13,488,737	13,532,558	0.664719	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	3,035	1,872,228	1,875,263	2.025571	90.02
91.00	09100	EMERGENCY	45,629,379	93,912,710	139,542,089	0.145896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	574,140	1,610,960	2,185,100	1.106361	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	1,810,941	10,119,807	11,930,748	0.414176	92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	10100	HOME HEALTH AGENCY	0	8,944,180	8,944,180		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	831,197,824	964,351,356	1,795,549,180		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	831,197,824	964,351,356	1,795,549,180		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 4:58 pm
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
43.00	04300 NURSERY			43.00
	<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	0.285019		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.682961		52.00
53.00	05300 ANESTHESIOLOGY	0.063830		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.093431		54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.087212		54.01
56.01	03480 ONCOLOGY	0.693911		56.01
60.00	06000 LABORATORY	0.134799		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.242756		62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500 RESPIRATORY THERAPY	0.147557		65.00
66.00	06600 PHYSICAL THERAPY	0.343348		66.00
66.01	06601 IP REHAB THERAPIES	0.425882		66.01
69.00	06900 ELECTROCARDIOLOGY	0.197290		69.00
69.01	03630 CARDIAC CATH LAB	0.088306		69.01
69.02	03160 CARDIAC REHABILITATION	0.000000		69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.242795		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.308734		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266274		73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000		73.01
74.00	07400 RENAL DIALYSIS	0.318469		74.00
76.97	07697 CARDIAC REHABILITATION	0.849472		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699 LI THOTRI PSY	0.000000		76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.664719		90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	2.025571		90.02
91.00	09100 EMERGENCY	0.145896		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.106361		92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.414176		92.01
	<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF			99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100 HOME HEALTH AGENCY			101.00
	<b>SPECIAL PURPOSE COST CENTERS</b>			
113.00	11300 INTEREST EXPENSE			113.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Title XIX		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000 ADULTS & PEDIATRICS	70,065,155		70,065,155	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	21,105,855		21,105,855	0	0 31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4,368,285		4,368,285	0	0 35.00
40.00	04000 SUBPROVIDER - I/PF	16,051,569		16,051,569	0	0 40.00
41.00	04100 SUBPROVIDER - I/RP	5,891,367		5,891,367	0	0 41.00
43.00	04300 NURSERY	3,972,084		3,972,084	0	0 43.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	42,215,216		42,215,216	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	9,310,871		9,310,871	0	0 52.00
53.00	05300 ANESTHESIOLOGY	818,990		818,990	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	38,473,592		38,473,592	0	0 54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	4,329,544		4,329,544	0	0 54.01
56.01	03480 ONCOLOGY	22,795,601		22,795,601	0	0 56.01
60.00	06000 LABORATORY	25,913,408		25,913,408	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	4,118,274		4,118,274	0	0 62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	4,864,345	0	4,864,345	0	0 65.00
66.00	06600 PHYSICAL THERAPY	15,030,751	0	15,030,751	0	0 66.00
66.01	06601 IP REHAB THERAPIES	3,293,971	0	3,293,971	0	0 66.01
69.00	06900 ELECTROCARDIOLOGY	10,892,271		10,892,271	0	0 69.00
69.01	03630 CARDIAC CATH LAB	4,961,884		4,961,884	0	0 69.01
69.02	03160 CARDIAC REHABILITATION	0		0	0	0 69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	37,022,389		37,022,389	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	23,868,294		23,868,294	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17,352,629		17,352,629	0	0 73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0		0	0	0 73.01
74.00	07400 RENAL DIALYSIS	2,296,381		2,296,381	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	3,112,147		3,112,147	0	0 76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699 LI THOTRI PSY	0		0	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01	09001 OUTPATIENT TREATMENT CENTERS	8,995,351		8,995,351	0	0 90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	3,798,478		3,798,478	0	0 90.02
91.00	09100 EMERGENCY	20,358,654		20,358,654	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,417,510		2,417,510	0	0 92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	4,941,426		4,941,426	0	0 92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910 CORF	0		0	0	0 99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0	0	0 99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0 99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0	0	0 99.40
101.00	10100 HOME HEALTH AGENCY	11,032,731		11,032,731	0	0 101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	443,669,023	0	443,669,023	0	0 200.00
201.00	Less Observation Beds	2,417,510		2,417,510		0 201.00
202.00	Total (see instructions)	441,251,513	0	441,251,513	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet C  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

			Title XIX			Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio				
	Inpatient	Outpatient	Total (col. 6 + col. 7)						
	6.00	7.00	8.00				9.00	10.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	0		0				30.00
31.00	03100	INTENSIVE CARE UNIT	0		0				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0		0				35.00
40.00	04000	SUBPROVIDER - I PF	0		0				40.00
41.00	04100	SUBPROVIDER - I RF	0		0				41.00
43.00	04300	NURSERY	0		0				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0.000000	0.000000		54.01
56.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000		56.01
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0.000000	0.000000		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000		66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0.000000	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000		69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0.000000	0.000000		69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000		73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0.000000	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0.000000	0.000000		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000		90.02
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0.000000	0.000000		92.01
<b>OTHER REIMBURSABLE COST CENTERS</b>									
99.10	09910	CORF	0	0	0				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0				99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0				101.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
113.00	11300	INTEREST EXPENSE							113.00
200.00		Subtotal (see instructions)	0	0	0				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	0	0	0				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet C Part I Date/Time Prepared: 2/27/2019 4:58 pm
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
INPATIENT ROUTINE SERVICE COST CENTERS			11.00		
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			35.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000		54.01
56.01	03480	ONCOLOGY	0.000000		56.01
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
66.01	06601	IP REHAB THERAPIES	0.000000		66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03630	CARDIAC CATH LAB	0.000000		69.01
69.02	03160	CARDIAC REHABILITATION	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0.000000		76.98
76.99	07699	LI THOTRI PSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000		90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000		92.01
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part I Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	12,626,404	0	12,626,404	70,427	179.28	30.00
31.00	INTENSIVE CARE UNIT	3,510,349		3,510,349	8,136	431.46	31.00
35.00	NEONATAL INTENSIVE CARE UNIT	554,261		554,261	3,397	163.16	35.00
40.00	SUBPROVIDER - IPF	2,537,721	0	2,537,721	13,799	183.91	40.00
41.00	SUBPROVIDER - IRF	1,385,651	0	1,385,651	5,906	234.62	41.00
43.00	NURSERY	566,847		566,847	5,059	112.05	43.00
200.00	Total (lines 30 through 199)	21,181,233		21,181,233	106,724		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	32,864	5,891,858				30.00
31.00	INTENSIVE CARE UNIT	4,158	1,794,011				31.00
35.00	NEONATAL INTENSIVE CARE UNIT	0	0				35.00
40.00	SUBPROVIDER - IPF	2,842	522,672				40.00
41.00	SUBPROVIDER - IRF	3,801	891,791				41.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	43,665	9,100,332				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,841,409	148,113,516	0.066445	25,590,918	1,700,389	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,751	13,633,093	0.103627	0	0	52.00
53.00	05300	ANESTHESIOLOGY	202,190	12,830,824	0.015758	2,894,566	45,613	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,377,649	411,916,877	0.017911	49,595,858	888,311	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,080,088	49,643,641	0.021757	158,440	3,447	54.01
56.01	03480	ONCOLOGY	3,027,078	32,890,237	0.092036	35,471	3,265	56.01
60.00	06000	LABORATORY	2,970,927	193,370,549	0.015364	38,895,106	597,584	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	358,253	16,964,664	0.021118	5,565,748	117,537	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	655,437	32,965,951	0.019882	16,493,104	327,916	65.00
66.00	06600	PHYSICAL THERAPY	2,727,240	43,777,041	0.062298	5,296,729	329,976	66.00
66.01	06601	IP REHAB THERAPIES	208,075	7,734,471	0.026902	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,899,467	57,363,508	0.033113	6,604,480	218,694	69.00
69.01	03630	CARDIAC CATH LAB	1,136,050	56,189,854	0.020218	10,799,875	218,352	69.01
69.02	03160	CARDIAC REHABILITATION	164,071	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,386,654	152,484,126	0.022210	38,583,953	856,950	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,181,914	77,310,153	0.028223	22,667,454	639,744	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,364,906	65,168,419	0.020944	25,337,083	530,660	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	148,697	7,210,679	0.020622	4,147,023	85,520	74.00
76.97	07697	CARDIAC REHABILITATION	858,867	3,663,625	0.234431	2,468	579	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	2,904,357	13,532,558	0.214620	16,438	3,528	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	613,843	1,875,263	0.327337	0	0	90.02
91.00	09100	EMERGENCY	3,016,469	139,542,089	0.021617	23,244,600	502,479	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	435,657	2,185,100	0.199376	521,113	103,897	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	376,253	11,930,748	0.031536	590,800	18,631	92.01
200.00		Total (lines 50 through 199)	48,348,302	1,552,296,986		277,041,227	7,193,072	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part III Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost
	1A	1.00	2A	2.00	3.00

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	27,475	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	15,424	0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	15,424	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30 through 199)	0	0	0	58,323	0	200.00

Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days
	4.00	5.00	6.00	7.00	8.00

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	27,475	70,427	0.39	32,864	30.00
31.00	03100	INTENSIVE CARE UNIT		15,424	8,136	1.90	4,158	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	3,397	0.00	0	35.00
40.00	04000	SUBPROVIDER - IPF	0	15,424	13,799	1.12	2,842	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,906	0.00	3,801	41.00
43.00	04300	NURSERY		0	5,059	0.00	0	43.00
200.00		Total (lines 30 through 199)		58,323	106,724		43,665	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		12,817				30.00
31.00	03100	INTENSIVE CARE UNIT		7,900				31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0				35.00
40.00	04000	SUBPROVIDER - IPF		3,183				40.00
41.00	04100	SUBPROVIDER - IRF		0				41.00
43.00	04300	NURSERY		0				43.00
200.00		Total (lines 30 through 199)		23,900				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description	Title XVIII				Hospital		PPS	
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	30,849	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	18,798	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0	56.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	I/P REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	347,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	948	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	397,642	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Title XVIII				Hospital		PPS	
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 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	30,849	30,849	148,113,516	0.000208	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,798	18,798	13,633,093	0.001379	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	12,830,824	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	411,916,877	0.000000	54.00	
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	49,643,641	0.000000	54.01	
56.01	03480	ONCOLOGY	0	0	0	32,890,237	0.000000	56.01	
60.00	06000	LABORATORY	0	0	0	193,370,549	0.000000	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	16,964,664	0.000000	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30	
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,965,951	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	43,777,041	0.000000	66.00	
66.01	06601	IP REHAB THERAPIES	0	0	0	7,734,471	0.000000	66.01	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	57,363,508	0.000000	69.00	
69.01	03630	CARDIAC CATH LAB	0	0	0	56,189,854	0.000000	69.01	
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	152,484,126	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,310,153	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	65,168,419	0.000000	73.00	
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000	73.01	
74.00	07400	RENAL DIALYSIS	0	0	0	7,210,679	0.000000	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	3,663,625	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98	
76.99	07699	LI THOTRI PSY	0	0	0	0	0.000000	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	13,532,558	0.000000	90.01	
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	1,875,263	0.000000	90.02	
91.00	09100	EMERGENCY	0	347,047	347,047	139,542,089	0.002487	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	948	948	2,185,100	0.000434	92.00	
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	11,930,748	0.000000	92.01	
200.00		Total (lines 50 through 199)	0	397,642	397,642	1,552,296,986		200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Title XVIII					
		Outpatient Ratio of Cost to Charges (col. 6 + col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Hospital Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000208	25,590,918	5,323	28,440,439	5,916	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.001379	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	2,894,566	0	1,833,413	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	49,595,858	0	106,921,426	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	158,440	0	15,291,950	0	54.01
56.01	03480 ONCOLOGY	0.000000	35,471	0	16,134,438	0	56.01
60.00	06000 LABORATORY	0.000000	38,895,106	0	17,706,435	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	5,565,748	0	1,245,471	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	16,493,104	0	736,495	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	5,296,729	0	1,522,188	0	66.00
66.01	06601 IP REHAB THERAPIES	0.000000	0	0	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	6,604,480	0	17,273,348	0	69.00
69.01	03630 CARDIAC CATH LAB	0.000000	10,799,875	0	15,747,772	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	38,583,953	0	22,781,864	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	22,667,454	0	17,086,671	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	25,337,083	0	3,388,187	0	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	4,147,023	0	136,975	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	2,468	0	1,798,398	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	16,438	0	1,535,708	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	116,012	0	90.02
91.00	09100 EMERGENCY	0.002487	23,244,600	57,809	24,229,666	60,259	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000434	521,113	226	1,610,795	699	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	590,800	0	1,450,826	0	92.01
200.00	Total (lines 50 through 199)		277,041,227	63,358	296,988,477	66,874	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:58 pm
Title XVIII			Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.285019	28,440,439	1	67	8,106,065	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.682961	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.063830	1,833,413	0	0	117,027	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.093401	106,921,426	1,813	7,090	9,986,568	54.00
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0.087212	15,291,950	5	1,396	1,333,642	54.01
56.01 03480 ONCOLOGY	0.693081	16,134,438	94	23,717	11,182,472	56.01
60.00 06000 LABORATORY	0.134009	17,706,435	0	0	2,372,822	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.242756	1,245,471	0	0	302,346	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.147557	736,495	0	0	108,675	65.00
66.00 06600 PHYSICAL THERAPY	0.343348	1,522,188	2	459	522,640	66.00
66.01 06601 IP REHAB THERAPIES	0.425882	0	0	0	0	66.01
69.00 06900 ELECTROCARDIOLOGY	0.189882	17,273,348	0	88	3,279,898	69.00
69.01 03630 CARDIAC CATH LAB	0.088306	15,747,772	72	630	1,390,623	69.01
69.02 03160 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.242795	22,781,864	0	11	5,531,323	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.308734	17,086,671	0	0	5,275,236	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.266274	3,388,187	19	5,069	902,186	73.00
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.318469	136,975	0	0	43,622	74.00
76.97 07697 CARDIAC REHABILITATION	0.849472	1,798,398	0	0	1,527,689	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001 OUTPATIENT TREATMENT CENTERS	0.664719	1,535,708	0	1,144	1,020,814	90.01
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	2.025571	116,012	0	0	234,991	90.02
91.00 09100 EMERGENCY	0.145896	24,229,666	21,949	3,078	3,535,011	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1.106361	1,610,795	4	161	1,782,121	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.414176	1,450,826	0	0	600,897	92.01
200.00	Subtotal (see instructions)	296,988,477	23,959	42,910	59,156,668	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 - line 201)	296,988,477	23,959	42,910	59,156,668	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	19		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	169	662		54.00
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0	122		54.01
56.01 03480 ONCOLOGY	65	16,438		56.01
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	1	158		66.00
66.01 06601 IP REHAB THERAPIES	0	0		66.01
69.00 06900 ELECTROCARDIOLOGY	0	17		69.00
69.01 03630 CARDIAC CATH LAB	6	56		69.01
69.02 03160 CARDIAC REHABILITATION	0	0		69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5	1,350		73.00
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01 09001 OUTPATIENT TREATMENT CENTERS	0	760		90.01
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	0	0		90.02
91.00 09100 EMERGENCY	3,202	449		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4	178		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00 Subtotal (see instructions)	3,452	20,212		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	3,452	20,212		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part II Date/Time Prepared: 2/27/2019 4:58 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,841,409	148,113,516	0.066445	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,751	13,633,093	0.103627	0	0	52.00
53.00	05300	ANESTHESIOLOGY	202,190	12,830,824	0.015758	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,377,649	411,916,877	0.017911	32,938	590	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,080,088	49,643,641	0.021757	0	0	54.01
56.01	03480	ONCOLOGY	3,027,078	32,890,237	0.092036	0	0	56.01
60.00	06000	LABORATORY	2,970,927	193,370,549	0.015364	208,347	3,201	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	358,253	16,964,664	0.021118	209	4	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	655,437	32,965,951	0.019882	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,727,240	43,777,041	0.062298	69,213	4,312	66.00
66.01	06601	I/P REHAB THERAPIES	208,075	7,734,471	0.026902	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,899,467	57,363,508	0.033113	11,659	386	69.00
69.01	03630	CARDIAC CATH LAB	1,136,050	56,189,854	0.020218	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	164,071	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,386,654	152,484,126	0.022210	769	17	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,181,914	77,310,153	0.028223	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,364,906	65,168,419	0.020944	206,874	4,333	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	148,697	7,210,679	0.020622	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	858,867	3,663,625	0.234431	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	2,904,357	13,532,558	0.214620	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	613,843	1,875,263	0.327337	0	0	90.02
91.00	09100	EMERGENCY	3,016,469	139,542,089	0.021617	721	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,185,100	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	376,253	11,930,748	0.031536	0	0	92.01
200.00		Total (lines 50 through 199)	47,912,645	1,552,296,986		530,730	12,859	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	30,849	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	18,798	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480 ONCOLOGY	0	0	0	0	0	56.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	347,047	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00	Total (lines 50 through 199)	0	0	0	0	396,694	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	30,849	30,849	148,113,516	0.000208	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,798	18,798	13,633,093	0.001379	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,830,824	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	411,916,877	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	49,643,641	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	32,890,237	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	193,370,549	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	16,964,664	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,965,951	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	43,777,041	0.000000	66.00
66.01	06601	I/P REHAB THERAPIES	0	0	0	7,734,471	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	57,363,508	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	56,189,854	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	152,484,126	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,310,153	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	65,168,419	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	7,210,679	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	3,663,625	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	13,532,558	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	1,875,263	0.000000	90.02
91.00	09100	EMERGENCY	0	347,047	347,047	139,542,089	0.002487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,185,100	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	11,930,748	0.000000	92.01
200.00		Total (lines 50 through 199)	0	396,694	396,694	1,552,296,986		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.000208	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001379	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	32,938	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	208,347	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	209	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	69,213	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	11,659	0	329	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	769	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	206,874	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	90.02
91.00	09100	EMERGENCY	0.002487	721	2	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	92.01
200.00		Total (lines 50 through 199)		530,730	2	329	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:58 pm
Title XVIII			Subprovider - IPF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.285019	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.682961	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.063830	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.093401	0	0	0	0	54.00
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0.087212	0	0	0	0	54.01
56.01 03480 ONCOLOGY	0.693081	0	0	0	0	56.01
60.00 06000 LABORATORY	0.134009	0	0	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.242756	0	0	0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.147557	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.343348	0	0	0	0	66.00
66.01 06601 IP REHAB THERAPIES	0.425882	0	0	0	0	66.01
69.00 06900 ELECTROCARDIOLOGY	0.189882	329	0	0	62	69.00
69.01 03630 CARDIAC CATH LAB	0.088306	0	0	0	0	69.01
69.02 03160 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.242795	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.308734	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.266274	0	0	0	0	73.00
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.318469	0	0	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0.849472	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.01 09001 OUTPATIENT TREATMENT CENTERS	0.664719	0	0	0	0	90.01
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	2.025571	0	0	0	0	90.02
91.00 09100 EMERGENCY	0.145896	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.106361	0	0	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.414176	0	0	0	0	92.01
200.00 Subtotal (see instructions)		329	0	0	62	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 - line 201)		329	0	0	62	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:58 pm
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0	0		54.01
56.01 03480 ONCOLOGY	0	0		56.01
60.00 06000 LABORATORY	0	0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
66.01 06601 IP REHAB THERAPIES	0	0		66.01
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
69.01 03630 CARDIAC CATH LAB	0	0		69.01
69.02 03160 CARDIAC REHABILITATION	0	0		69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0		74.00
76.97 07697 CARDIAC REHABILITATION	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01 09001 OUTPATIENT TREATMENT CENTERS	0	0		90.01
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	0	0		90.02
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part II Date/Time Prepared: 2/27/2019 4:58 pm	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,841,409	148,113,516	0.066445	55,814	3,709	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,751	13,633,093	0.103627	0	0	52.00
53.00	05300	ANESTHESIOLOGY	202,190	12,830,824	0.015758	10,200	161	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,377,649	411,916,877	0.017911	438,559	7,855	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,080,088	49,643,641	0.021757	0	0	54.01
56.01	03480	ONCOLOGY	3,027,078	32,890,237	0.092036	0	0	56.01
60.00	06000	LABORATORY	2,970,927	193,370,549	0.015364	662,813	10,183	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	358,253	16,964,664	0.021118	49,444	1,044	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	655,437	32,965,951	0.019882	533,180	10,601	65.00
66.00	06600	PHYSICAL THERAPY	2,727,240	43,777,041	0.062298	95,904	5,975	66.00
66.01	06601	I/P REHAB THERAPIES	208,075	7,734,471	0.026902	4,981,938	134,024	66.01
69.00	06900	ELECTROCARDIOLOGY	1,899,467	57,363,508	0.033113	36,096	1,195	69.00
69.01	03630	CARDIAC CATH LAB	1,136,050	56,189,854	0.020218	3,522	71	69.01
69.02	03160	CARDIAC REHABILITATION	164,071	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,386,654	152,484,126	0.022210	147,804	3,283	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,181,914	77,310,153	0.028223	16,142	456	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,364,906	65,168,419	0.020944	672,771	14,091	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	148,697	7,210,679	0.020622	248,257	5,120	74.00
76.97	07697	CARDIAC REHABILITATION	858,867	3,663,625	0.234431	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	2,904,357	13,532,558	0.214620	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	613,843	1,875,263	0.327337	0	0	90.02
91.00	09100	EMERGENCY	3,016,469	139,542,089	0.021617	4,810	104	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,185,100	0.000000	36	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	376,253	11,930,748	0.031536	580	18	92.01
200.00		Total (lines 50 through 199)	47,912,645	1,552,296,986		7,957,870	197,890	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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	Title XVIII	Subprovider - IRF	PPS
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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	30,849	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	18,798	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480 ONCOLOGY	0	0	0	0	0	56.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	347,047	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00	Total (lines 50 through 199)	0	0	0	0	396,694	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	30,849	30,849	148,113,516	0.000208	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,798	18,798	13,633,093	0.001379	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	12,830,824	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	411,916,877	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	49,643,641	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	32,890,237	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	193,370,549	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	16,964,664	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,965,951	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	43,777,041	0.000000	66.00
66.01	06601	I/P REHAB THERAPIES	0	0	0	7,734,471	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	57,363,508	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	56,189,854	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	152,484,126	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	77,310,153	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	65,168,419	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	7,210,679	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	3,663,625	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRI PSY	0	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	13,532,558	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	1,875,263	0.000000	90.02
91.00	09100	EMERGENCY	0	347,047	347,047	139,542,089	0.002487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,185,100	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	11,930,748	0.000000	92.01
200.00		Total (lines 50 through 199)	0	396,694	396,694	1,552,296,986		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000208	55,814		12	18	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.001379	0		0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.000000	10,200		0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	438,559		0	8,975	0 54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	0		0	1,587	0 54.01
56.01	03480 ONCOLOGY	0.000000	0		0	0	0 56.01
60.00	06000 LABORATORY	0.000000	662,813		0	0	0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	49,444		0	0	0 62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0		0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	533,180		0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.000000	95,904		0	0	0 66.00
66.01	06601 IP REHAB THERAPIES	0.000000	4,981,938		0	0	0 66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	36,096		0	181	0 69.00
69.01	03630 CARDIAC CATH LAB	0.000000	3,522		0	36	0 69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0		0	0	0 69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	147,804		0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	16,142		0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	672,771		0	0	0 73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0		0	0	0 73.01
74.00	07400 RENAL DIALYSIS	0.000000	248,257		0	0	0 74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0		0	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0		0	0	0 76.98
76.99	07699 LI THOTRIPSY	0.000000	0		0	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	0		0	0	0 90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0		0	0	0 90.02
91.00	09100 EMERGENCY	0.002487	4,810		12	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	36		0	0	0 92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	580		0	0	0 92.01
200.00	Total (lines 50 through 199)		7,957,870		24	10,797	0 200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:58 pm
Title XVIII			Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0.285019	18	0	0	5 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.682961	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.063830	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.093401	8,975	0	0	838 54.00
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0.087212	1,587	0	0	138 54.01
56.01 03480 ONCOLOGY	0.693081	0	0	0	0 56.01
60.00 06000 LABORATORY	0.134009	0	0	0	0 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.242756	0	0	0	0 62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00 06500 RESPIRATORY THERAPY	0.147557	0	0	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.343348	0	0	0	0 66.00
66.01 06601 IP REHAB THERAPIES	0.425882	0	0	0	0 66.01
69.00 06900 ELECTROCARDIOLOGY	0.189882	181	0	0	34 69.00
69.01 03630 CARDIAC CATH LAB	0.088306	36	0	0	3 69.01
69.02 03160 CARDIAC REHABILITATION	0.000000	0	0	0	0 69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.242795	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.308734	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.266274	0	0	0	0 73.00
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0 73.01
74.00 07400 RENAL DIALYSIS	0.318469	0	0	0	0 74.00
76.97 07697 CARDIAC REHABILITATION	0.849472	0	0	0	0 76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0 76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01 09001 OUTPATIENT TREATMENT CENTERS	0.664719	0	0	0	0 90.01
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	2.025571	0	0	0	0 90.02
91.00 09100 EMERGENCY	0.145896	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.106361	0	0	0	0 92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.414176	0	0	0	0 92.01
200.00 Subtotal (see instructions)		10,797	0	0	1,018 200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 - line 201)		10,797	0	0	1,018 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part V Date/Time Prepared: 2/27/2019 4:58 pm
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs		
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
	6.00	7.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 OFFSITE-DIAGNOSTIC SERVICES	0	0	54.01
56.01 03480 ONCOLOGY	0	0	56.01
60.00 06000 LABORATORY	0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
66.01 06601 IP REHAB THERAPIES	0	0	66.01
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
69.01 03630 CARDIAC CATH LAB	0	0	69.01
69.02 03160 CARDIAC REHABILITATION	0	0	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01 07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.01 09001 OUTPATIENT TREATMENT CENTERS	0	0	90.01
90.02 09002 PARTIAL HOSPITALIZATION PROGRAM	0	0	90.02
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	92.01
200.00 Subtotal (see instructions)	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00 Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part I Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00		
30.00	ADULTS & PEDIATRICS	12,626,404	0	12,626,404	70,427	179.28	30.00	
31.00	INTENSIVE CARE UNIT	3,510,349		3,510,349	8,136	431.46	31.00	
35.00	NEONATAL INTENSIVE CARE UNIT	554,261		554,261	3,397	163.16	35.00	
40.00	SUBPROVIDER - IPF	2,537,721	0	2,537,721	13,799	183.91	40.00	
41.00	SUBPROVIDER - IRF	1,385,651	0	1,385,651	5,906	234.62	41.00	
43.00	NURSERY	566,847		566,847	5,059	112.05	43.00	
200.00	Total (lines 30 through 199)	21,181,233		21,181,233	106,724		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	1,992	357,126					30.00
31.00	INTENSIVE CARE UNIT	540	232,988					31.00
35.00	NEONATAL INTENSIVE CARE UNIT	818	133,465					35.00
40.00	SUBPROVIDER - IPF	1,865	342,992					40.00
41.00	SUBPROVIDER - IRF	187	43,874					41.00
43.00	NURSERY	842	94,346					43.00
200.00	Total (lines 30 through 199)	6,244	1,204,791					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part II Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Title XIX			Hospital		Capital Costs (column 3 x column 4)	
		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	Cost		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,841,409	0	0.000000	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,751	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	202,190	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,377,649	0	0.000000	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	1,080,088	0	0.000000	0	0	54.01
56.01	03480	ONCOLOGY	3,027,078	0	0.000000	0	0	56.01
60.00	06000	LABORATORY	2,970,927	0	0.000000	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	358,253	0	0.000000	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	655,437	0	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,727,240	0	0.000000	0	0	66.00
66.01	06601	IP REHAB THERAPIES	208,075	0	0.000000	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	1,899,467	0	0.000000	0	0	69.00
69.01	03630	CARDIAC CATH LAB	1,136,050	0	0.000000	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	164,071	0	0.000000	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,386,654	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,181,914	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,364,906	0	0.000000	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	148,697	0	0.000000	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	858,867	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	2,904,357	0	0.000000	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	613,843	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	3,016,469	0	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	435,657	0	0.000000	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	376,253	0	0.000000	0	0	92.01
200.00		Total (lines 50 through 199)	48,348,302	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part III Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
			1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	27,475	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	15,424	0	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	35.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	15,424	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
200.00		Total (lines 30 through 199)	0	0	0	58,323	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
			4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	27,475	70,427	0.39	1,992	30.00	
31.00	03100	INTENSIVE CARE UNIT		15,424	8,136	1.90	540	31.00	
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	3,397	0.00	818	35.00	
40.00	04000	SUBPROVIDER - IPF	0	15,424	13,799	1.12	1,865	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	5,906	0.00	187	41.00	
43.00	04300	NURSERY		0	5,059	0.00	842	43.00	
200.00		Total (lines 30 through 199)		58,323	106,724		6,244	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	777						30.00
31.00	03100	INTENSIVE CARE UNIT	1,026						31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT	0						35.00
40.00	04000	SUBPROVIDER - IPF	2,089						40.00
41.00	04100	SUBPROVIDER - IRF	0						41.00
43.00	04300	NURSERY	0						43.00
200.00		Total (lines 30 through 199)	3,892						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description	Title XIX					Hospital		Allied Health Cost
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	30,849	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	18,798	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0	56.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601	I/P REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	347,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00		Total (lines 50 through 199)	0	0	0	0	396,694	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Title XIX				Hospital		
		All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	30,849	30,849	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,798	18,798	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0.000000	54.01
56.01	03480	ONCOLOGY	0	0	0	0	0.000000	56.01
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
66.01	06601	IP REHAB THERAPIES	0	0	0	0	0.000000	66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0.000000	69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0.000000	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	347,047	347,047	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000	92.01
200.00		Total (lines 50 through 199)	0	396,694	396,694	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Title XIX			Hospital		Cost
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.000000	0	0	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	0	54.01
56.01	03480 ONCOLOGY	0.000000	0	0	0	0	56.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0.000000	0	0	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0.000000	0	0	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	0	0	69.02
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
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	90.02
91.00	09100 EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	0	92.01
200.00	Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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	Title XIX	Subprovider - IPF	Cost
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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	30,849	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	18,798	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480 ONCOLOGY	0	0	0	0	0	56.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.01	09001 OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	347,047	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00	Total (lines 50 through 199)	0	0	0	0	396,694	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
		4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	30,849	30,849	0	0.000000 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,798	18,798	0	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000 54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0.000000 54.01
56.01	03480	ONCOLOGY	0	0	0	0	0.000000 56.01
60.00	06000	LABORATORY	0	0	0	0	0.000000 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000 66.00
66.01	06601	I/P REHAB THERAPIES	0	0	0	0	0.000000 66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000 69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0.000000 69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000 69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000 73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000 73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0.000000 90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000 90.02
91.00	09100	EMERGENCY	0	347,047	347,047	0	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0.000000 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000 92.01
200.00		Total (lines 50 through 199)	0	396,694	396,694	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0252 Component CCN: 14-S252		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm	
				Title XIX		Subprovider - IPF	Cost
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
66.01	06601	IP REHAB THERAPIES	0.000000	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0.000000	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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	Title XIX	Subprovider - IRF	Cost
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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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	30,849	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	18,798	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0	54.01
56.01	03480 ONCOLOGY	0	0	0	0	0	56.01
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
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0	0	0	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0	0	0	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0	0	0	0	0	69.02
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
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001 OUTPATIENT TREATMENT CENTERS	0	0	0	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	90.02
91.00	09100 EMERGENCY	0	0	0	0	347,047	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
200.00	Total (lines 50 through 199)	0	0	0	0	396,694	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		All Other Medical Education Cost	Total Cost (sum of col s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 + col. 7)	
		4.00	5.00	6.00	7.00	8.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	30,849	30,849	0	0.000000 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	18,798	18,798	0	0.000000 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0.000000 54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0	0	0	0	0.000000 54.01
56.01	03480	ONCOLOGY	0	0	0	0	0.000000 56.01
60.00	06000	LABORATORY	0	0	0	0	0.000000 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0.000000 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000 62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0.000000 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000 66.00
66.01	06601	I/P REHAB THERAPIES	0	0	0	0	0.000000 66.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000 69.00
69.01	03630	CARDIAC CATH LAB	0	0	0	0	0.000000 69.01
69.02	03160	CARDIAC REHABILITATION	0	0	0	0	0.000000 69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000 73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0	0	0	0	0.000000 73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000 74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0	0	0	0	0.000000 90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000 90.02
91.00	09100	EMERGENCY	0	347,047	347,047	0	0.000000 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0.000000 92.01
200.00		Total (lines 50 through 199)	0	396,694	396,694	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 14-0252 Component CCN: 14-T252		Period: From 10/01/2017 To 09/30/2018		Worksheet D Part IV Date/Time Prepared: 2/27/2019 4:58 pm	
				Title XIX		Subprovider - IRF	Cost
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0.000000	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	0	54.01
56.01	03480	ONCOLOGY	0.000000	0	0	0	56.01
60.00	06000	LABORATORY	0.000000	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	66.00
66.01	06601	I/P REHAB THERAPIES	0.000000	0	0	0	66.01
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	69.00
69.01	03630	CARDIAC CATH LAB	0.000000	0	0	0	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0.000000	0	0	0	76.98
76.99	07699	LITHOTRI PSY	0.000000	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.000000	0	0	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	0	92.01
200.00		Total (lines 50 through 199)		0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		70,427	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,427	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)		67,997	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)		32,864	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		70,065,155	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		70,065,155	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		70,065,155	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		994.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		32,695,079	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)		32,695,079	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	21,241,626	8,136	2,610.82	4,158	10,855,790	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 NEONATAL INTENSIVE CARE UNIT	4,368,285	3,397	1,285.92	0	0	47.00
Cost Center Description						
					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					53,913,067	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					97,463,936	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)					7,706,586	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,256,430	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					14,963,016	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					82,500,920	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,430	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					994.86	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,417,510	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	12,626,404	70,065,155	0.180209	2,417,510	435,657	90.00
91.00	Nursing School cost	0	70,065,155	0.000000	2,417,510	0	91.00
92.00	Allied health cost	27,475	70,065,155	0.000392	2,417,510	948	92.00
93.00	All other Medical Education	0	70,065,155	0.000000	2,417,510	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		13,799	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		13,799	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)		13,799	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,842	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		16,051,569	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)		16,051,569	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		16,051,569	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,163.24	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,305,928	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)		3,305,928	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1	
				Component CCN: 14-S252		Date/Time Prepared: 2/27/2019 4:58 pm	
				Title XVIII	Subprovider - IPF	PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					112,654		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,418,582		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					525,855		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					12,861		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					538,716		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,879,866		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 14-0252 Component CCN: 14-S252		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,537,721	16,051,569	0.158098	0	0	90.00
91.00	Nursing School cost	0	16,051,569	0.000000	0	0	91.00
92.00	Allied health cost	15,424	16,051,569	0.000961	0	0	92.00
93.00	All other Medical Education	0	16,051,569	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,906	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,906	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)		5,906	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)		3,801	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,891,367	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)		5,891,367	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,891,367	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		997.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,791,574	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)		3,791,574	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1	
				Component CCN: 14-T252		Date/Time Prepared: 2/27/2019 4:58 pm	
				Title XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,699,691		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,491,265		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					891,791		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					197,914		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,089,705		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					5,401,560		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 14-0252 Component CCN: 14-T252		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,385,651	5,891,367	0.235200	0	0	90.00
91.00	Nursing School cost	0	5,891,367	0.000000	0	0	91.00
92.00	Allied health cost	0	5,891,367	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,891,367	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		70,427	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		70,427	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)		67,997	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)		1,992	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)		5,059	15.00
16.00	Nursery days (title V or XIX only)		842	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		70,065,155	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		70,065,155	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		70,065,155	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		994.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,981,761	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)		1,981,761	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm		
Cost Center Description			Title XIX		Hospital	Cost	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	1.00	2.00	3.00	4.00	5.00		
42.00	3,972,084	5,059	785.15	842	661,096	42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00	21,105,855	8,136	2,594.13	540	1,400,830	43.00	
44.00						44.00	
45.00						45.00	
46.00						46.00	
47.00	4,368,285	3,397	1,285.92	818	1,051,883	47.00	
<b>Cost Center Description</b>							
48.00					1.00	0	
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)					5,095,570	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					2,430	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					994.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,417,510	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	12,626,404	70,065,155	0.180209	2,417,510	435,657	90.00
91.00	Nursing School cost	0	70,065,155	0.000000	2,417,510	0	91.00
92.00	Allied health cost	27,475	70,065,155	0.000392	2,417,510	948	92.00
93.00	All other Medical Education	0	70,065,155	0.000000	2,417,510	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			13,799 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			13,799 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)			13,799 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)			1,865 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)			5,059 15.00
16.00	Nursery days (title V or XIX only)			842 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			16,051,569 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)			16,051,569 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			16,051,569 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,163.24 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,169,443 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			2,169,443 41.00

COMPUTATION OF INPATIENT OPERATING COST					Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1
					Component CCN: 14-S252		Date/Time Prepared: 2/27/2019 4:58 pm
					Title XIX	Subprovider - IPF	Cost
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)		
	Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)				
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00	
<b>Intensive Care Type Inpatient Hospital Units</b>							
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 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	47.00	
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,169,443	49.00	
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					0	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00	
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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	
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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	
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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	
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 14-0252 Component CCN: 14-S252		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XIX		Subprovider - IPF		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,537,721	16,051,569	0.158098	0	0	90.00
91.00	Nursing School cost	0	16,051,569	0.000000	0	0	91.00
92.00	Allied health cost	15,424	16,051,569	0.000961	0	0	92.00
93.00	All other Medical Education	0	16,051,569	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm
		Title XIX	Subprovider - IRF	Cost
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,906 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,906 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)			5,906 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)			187 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)			5,059 15.00
16.00	Nursery days (title V or XIX only)			842 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			5,891,367 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)			5,891,367 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			5,891,367 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			997.52 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			186,536 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)			186,536 41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1	
				Component CCN: 14-T252		Date/Time Prepared: 2/27/2019 4:58 pm	
				Title XIX	Subprovider - IRF	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 NEONATAL INTENSIVE CARE UNIT	0	0	0.00	0	0	0	47.00
<b>Cost Center Description</b>							
					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)						186,536	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</b>							
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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 14-0252 Component CCN: 14-T252		Period: From 10/01/2017 To 09/30/2018		Worksheet D-1 Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XIX		Subprovider - IRF		Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,385,651	5,891,367	0.235200	0	0	90.00
91.00	Nursing School cost	0	5,891,367	0.000000	0	0	91.00
92.00	Allied health cost	0	5,891,367	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,891,367	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		61,187,376	30.00
31.00	03100	INTENSIVE CARE UNIT		21,376,168	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - I PF		6,693	40.00
41.00	04100	SUBPROVIDER - I RF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.285019	25,590,918	7,293,898 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682961	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.063830	2,894,566	184,760 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093431	49,595,858	4,633,791 54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.087212	158,440	13,818 54.01
56.01	03480	ONCOLOGY	0.693911	35,471	24,614 56.01
60.00	06000	LABORATORY	0.134799	38,895,106	5,243,021 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.242756	5,565,748	1,351,119 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.147557	16,493,104	2,433,673 65.00
66.00	06600	PHYSICAL THERAPY	0.343348	5,296,729	1,818,621 66.00
66.01	06601	IP REHAB THERAPIES	0.425882	0	0 66.01
69.00	06900	ELECTROCARDIOLOGY	0.197290	6,604,480	1,302,998 69.00
69.01	03630	CARDIAC CATH LAB	0.088306	10,799,875	953,694 69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	0 69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242795	38,583,953	9,367,991 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.308734	22,667,454	6,998,214 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266274	25,337,083	6,746,606 73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0 73.01
74.00	07400	RENAL DIALYSIS	0.318469	4,147,023	1,320,698 74.00
76.97	07697	CARDIAC REHABILITATION	0.849472	2,468	2,096 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699	LITHOTRIpsy	0.000000	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.664719	16,438	10,927 90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	2.025571	0	0 90.02
91.00	09100	EMERGENCY	0.145896	23,244,600	3,391,294 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.106361	521,113	576,539 92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.414176	590,800	244,695 92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		277,041,227	53,913,067 200.00
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)		277,041,227	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - IPF		6,773,495		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.285019	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.682961	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.063830	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.093431	32,938	3,077	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.087212	0	0	54.01
56.01	03480 ONCOLOGY	0.693911	0	0	56.01
60.00	06000 LABORATORY	0.134799	208,347	28,085	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.242756	209	51	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.147557	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.343348	69,213	23,764	66.00
66.01	06601 IP REHAB THERAPIES	0.425882	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.197290	11,659	2,300	69.00
69.01	03630 CARDIAC CATH LAB	0.088306	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.242795	769	187	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.308734	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.266274	206,874	55,085	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.318469	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.849472	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.664719	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	2.025571	0	0	90.02
91.00	09100 EMERGENCY	0.145896	721	105	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.106361	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.414176	0	0	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		530,730	112,654	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)		530,730		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000	SUBPROVIDER - I PF		0	40.00
41.00	04100	SUBPROVIDER - IRF		6,620,312	41.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.285019	55,814	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.682961	0	52.00
53.00	05300	ANESTHESIOLOGY	0.063830	10,200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.093431	438,559	54.00
54.01	05401	OFFSITE-DIAGNOSTIC SERVICES	0.087212	0	54.01
56.01	03480	ONCOLOGY	0.693911	0	56.01
60.00	06000	LABORATORY	0.134799	662,813	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.242756	49,444	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.147557	533,180	65.00
66.00	06600	PHYSICAL THERAPY	0.343348	95,904	66.00
66.01	06601	IP REHAB THERAPIES	0.425882	4,981,938	66.01
69.00	06900	ELECTROCARDIOLOGY	0.197290	36,096	69.00
69.01	03630	CARDIAC CATH LAB	0.088306	3,522	69.01
69.02	03160	CARDIAC REHABILITATION	0.000000	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.242795	147,804	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.308734	16,142	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.266274	672,771	73.00
73.01	07301	FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0.318469	248,257	74.00
76.97	07697	CARDIAC REHABILITATION	0.849472	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001	OUTPATIENT TREATMENT CENTERS	0.664719	0	90.01
90.02	09002	PARTIAL HOSPITALIZATION PROGRAM	2.025571	0	90.02
91.00	09100	EMERGENCY	0.145896	4,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.106361	36	92.00
92.01	09201	OBSERVATION BEDS (DISTINCT PART)	0.414176	580	92.01
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,957,870	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		7,957,870	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 4:58 pm
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0		35.00
40.00	04000 SUBPROVIDER - I PF		0		40.00
41.00	04100 SUBPROVIDER - I RF		0		41.00
43.00	04300 NURSERY		0		43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.000000	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	0	54.01
56.01	03480 ONCOLOGY	0.000000	0	0	56.01
60.00	06000 LABORATORY	0.000000	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	66.00
66.01	06601 IP REHAB THERAPIES	0.000000	0	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03630 CARDIAC CATH LAB	0.000000	0	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	0	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	90.02
91.00	09100 EMERGENCY	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	0	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	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)		0	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet D-3 Date/Time Prepared: 2/27/2019 4:58 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
		1.00	2.00	3.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS		0	30.00
31.00	03100 INTENSIVE CARE UNIT		0	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		0	35.00
40.00	04000 SUBPROVIDER - IPF		0	40.00
41.00	04100 SUBPROVIDER - IRF		0	41.00
43.00	04300 NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0.000000	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	0	54.00
54.01	05401 OFFSITE-DIAGNOSTIC SERVICES	0.000000	0	54.01
56.01	03480 ONCOLOGY	0.000000	0	56.01
60.00	06000 LABORATORY	0.000000	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.000000	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	66.00
66.01	06601 IP REHAB THERAPIES	0.000000	0	66.01
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	69.00
69.01	03630 CARDIAC CATH LAB	0.000000	0	69.01
69.02	03160 CARDIAC REHABILITATION	0.000000	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	0	73.00
73.01	07301 FLU VACCINE DRUGS CHG TO PATIENTS	0.000000	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.01	09001 OUTPATIENT TREATMENT CENTERS	0.000000	0	90.01
90.02	09002 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	90.02
91.00	09100 EMERGENCY	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0.000000	0	92.01
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00	Net charges (line 200 minus line 201)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Hospital	PPS
		1.00		
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		79,109,485	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)		1,152,611	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)		405.34	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.37	30.00
31.00	Percentage of Medicaid patient days (see instructions)		12.87	31.00
32.00	Sum of lines 30 and 31		15.24	32.00
33.00	Allowable disproportionate share percentage (see instructions)		2.66	33.00
34.00	Disproportionate share adjustment (see instructions)		526,078	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0	6,766,695,164	35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000365328	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	2,472,063	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	2,472,063	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,472,063		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
		Before 1/1	On/After 1/1		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		83,260,237		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)			83,260,237	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			6,945,706	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			55,565	53.00
54.00	Special add-on payments for new technologies			29,054	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).			20,717	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			63,358	58.00
59.00	Total (sum of amounts on lines 49 through 58)			90,374,637	59.00
60.00	Primary payer payments			26,192	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			90,348,445	61.00
62.00	Deductibles billed to program beneficiaries			7,961,860	62.00
63.00	Coinurance billed to program beneficiaries			198,001	63.00
64.00	Allowable bad debts (see instructions)			995,841	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			647,297	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			725,503	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			82,835,881	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 ADJ-ALLIED HEALTH A&G			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)			-416,536	70.93
70.94	HRR adjustment amount (see instructions)			-126,619	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part A Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	1.00	0 70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0 70.97
70.98	Low Volume Payment-3			0 70.98
70.99	HAC adjustment amount (see instructions)			0 70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		82,292,726	71.00
71.01	Sequestration adjustment (see instructions)		1,645,855	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		78,090,536	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)		2,556,335	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,539,704	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0 90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0 91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0 92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0 93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
<b>HSP Bonus Payment Amount</b>				
100.00	HSP bonus amount (see instructions)			0 100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
<b>Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment</b>				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
<b>Cost Reimbursement</b>				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
<b>Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)</b>				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
<b>Adjustment to Medicare Part A Inpatient Reimbursement</b>				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
<b>Comparison of PPS versus Cost Reimbursement</b>				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	79,109,485	0	0	79,109,485	79,109,485	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	1,152,611	0	0	1,152,611	1,152,611	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000	5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000	7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0266	0.0266	0.0266	0.0266	0.0266	10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	526,078	0	0	526,078	526,078	11.00
11.01	Uncompensated care payments	36.00	2,472,063	0	0	1,639,612	1,639,612	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	83,260,237	0	0	83,260,237	83,260,237	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	83,260,237	0	0	83,260,237	83,260,237	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	6,945,706	0	0	6,945,706	6,945,706	16.00
17.00	Special add-on payments for new technologies	54.00	29,054	0	0	29,054	29,054	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Title XVIII			Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01 3.00	Period On/After 10/01 4.00	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	90,234,997	90,234,997	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	6,443,075	0	0	6,443,075	6,443,075	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	300,318	0	0	300,318	300,318	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	0.0314	0.0314	0.0314	0.0314		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	202,313	0	0	202,313	202,313	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,945,706	0	0	6,945,706	6,945,706	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: 14-0252		Period: From 10/01/2017 To 09/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XVIII		Hospital		PPS	
	Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (col. 2 and 3)		
	0	1.00	2.00	3.00	4.00		
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	79,109,485		79,109,485	79,109,485	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,152,611	0	1,152,611	1,152,611	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
<b>Disproportionate Share Adjustment</b>							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0266	0.0266	0.0266		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	526,078	0	526,078	526,078	11.00
11.01	Uncompensated care payments	36.00	2,472,063	0	2,472,063	2,472,063	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	83,260,237	0	83,260,237	83,260,237	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	83,260,237	0	83,260,237	83,260,237	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	6,945,706	0	6,945,706	6,945,706	16.00
17.00	Special add-on payments for new technologies	54.00	29,054	0	29,054	29,054	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			0	90,234,997	90,234,997	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet E  
Part A Exhibit 5  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	6,443,075	0	6,443,075	6,443,075	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	300,318	0	300,318	300,318	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	0.0314	0.0314	0.0314		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	202,313	0	202,313	202,313	25.00
26.00	Total prospective capital payments (see instructions)	12.00	6,945,706	0	6,945,706	6,945,706	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	-416,536	0	-416,536	-416,536	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	-126,619	0	-126,619	-126,619	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		32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		23,664	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		59,089,794	2.00
3.00	OPPS payments		51,898,733	3.00
4.00	Outlier payment (see instructions)		32,093	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.899	5.00
6.00	Line 2 times line 5		53,121,725	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		97.76	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		66,874	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		23,664	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		66,869	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)		66,869	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		66,869	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		43,205	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)		23,664	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)		51,997,700	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		4,763	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		9,852,101	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)		42,164,500	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)		42,164,500	30.00
31.00	Primary payer payments		3,798	31.00
32.00	Subtotal (line 30 minus line 31)		42,160,702	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		1,053,940	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		685,061	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		925,251	36.00
37.00	Subtotal (see instructions)		42,845,763	37.00
38.00	MSP-LCC reconciliation amount from PS&R		290	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)		42,845,473	40.00
40.01	Sequestration adjustment (see instructions)		856,909	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		42,020,341	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-31,777	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		62	2.00
3.00	OPPS payments		58	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		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		58	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		12	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)		46	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)		46	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		46	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		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)		46	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)		46	40.00
40.01	Sequestration adjustment (see instructions)		1	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		45	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		1,018	2.00
3.00	OPPS payments		2,490	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		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		2,490	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		498	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)		1,992	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)		1,992	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		1,992	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		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)		1,992	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)		1,992	40.00
40.01	Sequestration adjustment (see instructions)		40	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		1,952	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		77,432,021		41,244,928	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		658,515		775,413	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)		78,090,536		42,020,341	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		2,556,335		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		31,777	6.02	
7.00	Total Medicare program liability (see instructions)		80,646,871		41,988,564	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: 14-0252  
Component CCN: 14-S252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Title XVIII

Subprovider -  
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					45 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		2,335,325			0 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		62,576			0 3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0			0 3.01
3.02			0			0 3.02
3.03			0			0 3.03
3.04			0			0 3.04
3.05			0			0 3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0			0 3.50
3.51			0			0 3.51
3.52			0			0 3.52
3.53			0			0 3.53
3.54			0			0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0			0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,397,901			45 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)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		12,461			0 6.01
6.02	SETTLEMENT TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		2,410,362			45 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: 14-0252  
Component CCN: 14-T252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Title XVIII

Subprovider -  
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		6,391,927		1,952	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)		6,391,927		1,952	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		40,780		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,432,707		1,952	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: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part II Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,674,873 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			37.805479 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9}))\}$ raised to the power of .5150 -1.			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,674,873 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,674,873 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,674,873 18.00
19.00	Deductibles			207,984 19.00
20.00	Subtotal (line 18 minus line 19)			2,466,889 20.00
21.00	Coinsurance			83,899 21.00
22.00	Subtotal (line 20 minus line 21)			2,382,990 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			112,889 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			73,378 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			81,484 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,456,368 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			3,185 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,459,553 31.00
31.01	Sequestration adjustment (see instructions)			49,191 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,397,901 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			12,461 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part III Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			6,178,765 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0238 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			137,169 3.00
4.00	Outlier Payments			292,532 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)			16.180822 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)			6,608,466 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)			6,608,466 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			6,608,466 19.00
20.00	Deductibles			23,976 20.00
21.00	Subtotal (line 19 minus line 20)			6,584,490 21.00
22.00	Coinsurance			27,798 22.00
23.00	Subtotal (line 21 minus line 22)			6,556,692 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			11,186 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			7,271 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			11,186 26.00
27.00	Subtotal (sum of lines 23 and 25)			6,563,963 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)			24 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)			6,563,987 32.00
32.01	Sequestration adjustment (see instructions)			131,280 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			6,391,927 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)			40,780 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			7,010 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			292,532 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2019 4:58 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>					
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>					
1.00	Inpatient hospital/SNF/NF services		5,095,570		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5,095,570	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5,095,570	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>					
<b>Reasonable Charges</b>					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
<b>CUSTOMARY CHARGES</b>					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		5,095,570	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>					
30.00	Excess of reasonable cost (from line 18)		5,095,570	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-S252	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2019 4:58 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	2,169,443		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	2,169,443	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	2,169,443	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	2,169,443	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	2,169,443	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 Component CCN: 14-T252	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part VII Date/Time Prepared: 2/27/2019 4:58 pm
		Title XIX	Subprovider - IRF	Cost
		Inpatient 1.00	Outpatient 2.00	
<b>PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES</b>				
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>				
1.00	Inpatient hospital/SNF/NF services	186,536		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	186,536	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	186,536	0	7.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable Charges</b>				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
<b>CUSTOMARY CHARGES</b>				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	186,536	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
<b>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.</b>				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
30.00	Excess of reasonable cost (from line 18)	186,536	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet G  
Date/Time Prepared:  
2/27/2019 4:58 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	15,315,827	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	56,508,909	0	0	0	4.00
5.00	Other receivable	29,503,880	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	8,765,876	0	0	0	8.00
9.00	Other current assets	4,428,314	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	114,522,806	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	89,072	0	0	0	12.00
13.00	Land improvements	14,779,813	0	0	0	13.00
14.00	Accumulated depreciation	-11,963,173	0	0	0	14.00
15.00	Buildings	314,818,703	0	0	0	15.00
16.00	Accumulated depreciation	-150,422,368	0	0	0	16.00
17.00	Leasehold improvements	3,480,507	0	0	0	17.00
18.00	Accumulated depreciation	-2,049,460	0	0	0	18.00
19.00	Fixed equipment	215,331,538	0	0	0	19.00
20.00	Accumulated depreciation	-125,796,696	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	230,280,363	0	0	0	23.00
24.00	Accumulated depreciation	-127,605,875	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)	360,942,424	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	9,482,983	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	23,789,577	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,272,560	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	508,737,790	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	21,371,481	0	0	0	37.00
38.00	Salaries, wages, and fees payable	37,813,492	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,600,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	46,938,506	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	113,723,479	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	259,596,668	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)	259,596,668	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	373,320,147	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	135,417,643				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)	135,417,643	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	508,737,790	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet G-1

Date/Time Prepared:  
2/27/2019 4:58 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		186,892,728		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,853,919			2.00
3.00	Total (sum of line 1 and line 2)		195,746,647		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	RESTRICTED NET ASSETS TRANSFER	0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		195,746,647		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00	RESTRICTED NET ASSETS TRANSFER	60,329,001		0		13.00
14.00	RECONCILING ITEM	3		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		60,329,004		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		135,417,643		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00	RESTRICTED NET ASSETS TRANSFER		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	RESTRICTED NET ASSETS TRANSFER		0			13.00
14.00	RECONCILING ITEM		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: 14-0252

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	164,538,888		164,538,888	1.00
2.00	SUBPROVIDER - IPF	21,280,330		21,280,330	2.00
3.00	SUBPROVIDER - IRF	18,030,790		18,030,790	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)	203,850,008		203,850,008	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	43,309,574		43,309,574	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	NEONATAL INTENSIVE CARE UNIT	11,913,639		11,913,639	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	55,223,213		55,223,213	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	259,073,221		259,073,221	17.00
18.00	Ancillary services	567,267,714	947,025,672	1,514,293,386	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		8,944,180	8,944,180	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	RESIDENTIAL TREATMENT CENTER	2,394,621	379,663	2,774,284	27.00
27.01	OTHER NRCC CHARGES	3,703,431	13,286,712	16,990,143	27.01
27.02	MOBILE DENTAL CLINIC	0	910,982	910,982	27.02
27.03	CORPORATE HEALTH	0	-2,794	-2,794	27.03
27.04	OTHER (SPECIFY)	0	0	0	27.04
27.05	OTHER (SPECIFY)	0	0	0	27.05
27.06	RECONCILING ITEM	0	1	1	27.06
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	832,438,987	970,544,416	1,802,983,403	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		467,701,198		29.00
30.00	MISC WORKSHEET A-8 ADJUSTMENT	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	OTHER	0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	PROVISION FOR BAD DEBT - MISC RECEIP	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)		467,701,198		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet G-3 Date/Time Prepared: 2/27/2019 4:58 pm
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,802,983,403	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,323,086,838	2.00
3.00	Net patient revenues (line 1 minus line 2)	479,896,565	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	467,701,198	4.00
5.00	Net income from service to patients (line 3 minus line 4)	12,195,367	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	1,412,184	6.00
7.00	Income from investments	316,618	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	66,965	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	1,872,035	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	1,001,816	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYSICIANS OFFICES	1,883,368	24.00
24.01	OTHER REVENUE - ACCT 533990	2,649,669	24.01
24.02	MGT SERVICES	897,159	24.02
24.03	OTHER MISC	3,774	24.03
24.04	OP PHARMACY	1,736,752	24.04
24.05	RESEARCH	155,608	24.05
24.06	LOSS ON SALE OF INVESTMENT	-111,462	24.06
24.07	NON OPERATING REVENUE	-15,225,938	24.07
25.00	Total other income (sum of lines 6-24)	-3,341,452	25.00
26.00	Total (line 5 plus line 25)	8,853,915	26.00
27.00	RECONCILING ITEM	-4	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-4	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	8,853,919	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0252

Period: From 10/01/2017

Worksheet H

HHA CCN: 14-7094

To 09/30/2018

Date/Time Prepared: 2/27/2019 4:58 pm

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	39,983	39,983	3.00
4.00	0	0	0	0	0	0	4.00
5.00	954,524	69,440	0	1,075,110	42,353	2,141,427	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	1,952,745	142,062	54,797	32,284	0	2,181,888	6.00
7.00	1,676,648	121,976	51,222	0	0	1,849,846	7.00
8.00	390,470	28,407	11,136	0	0	430,013	8.00
9.00	49,824	3,625	1,650	0	0	55,099	9.00
10.00	61,441	4,470	472	0	0	66,383	10.00
11.00	64,115	4,664	4,002	0	0	72,781	11.00
12.00	0	0	0	0	226,249	226,249	12.00
13.00	0	0	0	0	1,065	1,065	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
23.50	0	0	0	0	0	0	23.50
24.00	5,149,767	374,644	123,279	1,107,394	309,650	7,064,734	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	39,983	0	39,983			3.00
4.00	0	0	0	0			4.00
5.00	0	2,141,427	0	2,141,427			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	560	2,182,448	0	2,182,448			6.00
7.00	0	1,849,846	0	1,849,846			7.00
8.00	0	430,013	0	430,013			8.00
9.00	0	55,099	0	55,099			9.00
10.00	0	66,383	0	66,383			10.00
11.00	0	72,781	0	72,781			11.00
12.00	0	226,249	0	226,249			12.00
13.00	0	1,065	0	1,065			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
23.50	0	0	0	0			23.50
24.00	560	7,065,294	0	7,065,294			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet H-1 Part I Date/Time Prepared: 2/27/2019 4:58 pm
		HHA CCN: 14-7094	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bldgs & Fixtures	Movable Equipment				
		1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0		0		0	2.00
3.00	Plant Operation & Maintenance	39,983	0	0	39,983	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	2,141,427	0	0	39,983	0	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	2,182,448	0	0	0	2,182,448	6.00
7.00	Physical Therapy	1,849,846	0	0	0	1,849,846	7.00
8.00	Occupational Therapy	430,013	0	0	0	430,013	8.00
9.00	Speech Pathology	55,099	0	0	0	55,099	9.00
10.00	Medical Social Services	66,383	0	0	0	66,383	10.00
11.00	Home Health Aide	72,781	0	0	0	72,781	11.00
12.00	Supplies (see instructions)	226,249	0	0	0	226,249	12.00
13.00	Drugs	1,065	0	0	0	1,065	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Tel emedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	7,065,294	0	0	39,983	0	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	2,181,410					5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	1,044,525	3,226,973				6.00
7.00	Physical Therapy	787,307	2,637,153				7.00
8.00	Occupational Therapy	104,070	534,083				8.00
9.00	Speech Pathology	14,244	69,343				9.00
10.00	Medical Social Services	74,471	140,854				10.00
11.00	Home Health Aide	37,546	110,327				11.00
12.00	Supplies (see instructions)	35,443	261,692				12.00
13.00	Drugs	125	1,190				13.00
14.00	DME	0	0				14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	All Others (specify)	83,679	83,679				23.00
23.50	Tel emedicine	0	0				23.50
24.00	Total (sum of lines 1-23)		7,065,294				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0252

Period: From 10/01/2017

Worksheet H-1

HHA CCN: 14-7094

To 09/30/2018

Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	100	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	100	0	-2,181,410	18,519,164
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	6,685,080	8,867,528
7.00	Physical Therapy	0	0	0	0	4,834,025	6,683,871
8.00	Occupational Therapy	0	0	0	0	453,495	883,508
9.00	Speech Pathology	0	0	0	0	65,829	120,928
10.00	Medical Social Services	0	0	0	0	565,843	632,226
11.00	Home Health Aide	0	0	0	0	245,964	318,745
12.00	Supplies (see instructions)	0	0	0	0	74,650	300,899
13.00	Drugs	0	0	0	0	0	1,065
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	710,394	710,394
23.50	Telemedicine	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	100	0	11,453,870	18,519,164
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	39,983	0		2,181,410
26.00	Unit Cost Multiplier	0.000000	0.000000	399.830000	0.000000		0.117792

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0252

Period: From 10/01/2017

Worksheet H-2

HHA CCN: 14-7094

To 09/30/2018

Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Home Health Agency I

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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
	0	303,883	17,223	167,010	488,116	156,196	1.00	
1.00 Administrative and General	0	303,883	17,223	167,010	488,116	156,196	1.00	
2.00 Skilled Nursing Care	3,226,973	0	0	341,478	3,568,451	975,211	2.00	
3.00 Physical Therapy	2,637,153	0	0	293,197	2,930,350	789,183	3.00	
4.00 Occupational Therapy	534,083	0	0	68,282	602,365	122,615	4.00	
5.00 Speech Pathology	69,343	0	0	8,713	78,056	13,767	5.00	
6.00 Medical Social Services	140,854	0	0	10,744	151,598	53,318	6.00	
7.00 Home Health Aide	110,327	0	0	11,212	121,539	46,376	7.00	
8.00 Supplies (see instructions)	261,692	0	0	0	261,692	74,437	8.00	
9.00 Drugs	1,190	0	0	0	1,190	392	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	83,679	0	0	0	83,679	21,112	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	7,065,294	303,883	17,223	900,636	8,287,036	2,252,607	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA		
	6.00	7.00	8.00	9.00	10.00	11.00		
1.00 Administrative and General	0	375,197	0	117,485	0	0	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
19.50 Telemedicine	0	0	0	0	0	0	19.50	
20.00 Total (sum of lines 1-19) (2)	0	375,197	0	117,485	0	0	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0252

Period: From 10/01/2017

Worksheet H-2

HHA CCN: 14-7094

To 09/30/2018

Part I  
Date/Time Prepared:  
2/27/2019 4:58 pm

Home Health Agency I

PPS

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	406	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	406	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

  

Cost Center Description		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMEDICAL PRGM	Subtotal	
				SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
		19.00	20.00	21.00	22.00	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	1,136,994	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	4,543,662	2.00
3.00	Physical Therapy	0	0	0	0	0	3,719,533	3.00
4.00	Occupational Therapy	0	0	0	0	0	724,980	4.00
5.00	Speech Pathology	0	0	0	0	0	91,823	5.00
6.00	Medical Social Services	0	0	0	0	0	204,916	6.00
7.00	Home Health Aide	0	0	0	0	0	167,915	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	336,129	8.00
9.00	Drugs	0	0	0	0	0	1,988	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	104,791	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	11,032,731	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 14-0252	Period: From 10/01/2017	Worksheet H-2 Part I
		HHA CCN: 14-7094	To 09/30/2018	Date/Time Prepared: 2/27/2019 4:58 pm
			Home Health Agency I	PPS

Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
	25.00	26.00	27.00	28.00		
1.00 Administrative and General	0	1,136,994				1.00
2.00 Skilled Nursing Care	0	4,543,662	522,058	5,065,720		2.00
3.00 Physical Therapy	0	3,719,533	427,363	4,146,896		3.00
4.00 Occupational Therapy	0	724,980	83,298	808,278		4.00
5.00 Speech Pathology	0	91,823	10,550	102,373		5.00
6.00 Medical Social Services	0	204,916	23,544	228,460		6.00
7.00 Home Health Aide	0	167,915	19,293	187,208		7.00
8.00 Supplies (see instructions)	0	336,129	38,620	374,749		8.00
9.00 Drugs	0	1,988	228	2,216		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	104,791	12,040	116,831		19.00
19.50 Telemedicine	0	0	0	0		19.50
20.00 Total (sum of lines 1-19) (2)	0	11,032,731	1,136,994	11,032,731		20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.114897			21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0252

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part II

HHA CCN: 14-7094

Home Health Agency I

Date/Time Prepared: 2/27/2019 4:58 pm

PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	5,176	16,693	955,046	-13,747	474,369		1.00
2.00 Skilled Nursing Care	0	0	1,952,745	-606,739	2,961,712		2.00
3.00 Physical Therapy	0	0	1,676,648	-533,600	2,396,750		3.00
4.00 Occupational Therapy	0	0	390,470	-229,982	372,383		4.00
5.00 Speech Pathology	0	0	49,824	-36,247	41,809		5.00
6.00 Medical Social Services	0	0	61,441	10,329	161,927		6.00
7.00 Home Health Aide	0	0	64,115	19,304	140,843		7.00
8.00 Supplies (see instructions)	0	0	0	-35,627	226,065		8.00
9.00 Drugs	0	0	0	0	1,190		9.00
10.00 DME	0	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0	0		13.00
14.00 Clinic	0	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	-19,563	64,116		19.00
19.50 Telemedicine	0	0	0	0	0		19.50
20.00 Total (sum of lines 1-19)	5,176	16,693	5,150,289		6,841,164		20.00
21.00 Total cost to be allocated	303,883	17,223	900,636		2,252,607		21.00
22.00 Unit cost multiplier	58.710008	1.031750	0.174871		0.329272	0.000000	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	
	7.00	8.00	9.00	10.00	11.00	12.00	
1.00 Administrative and General	5,176	0	5,176	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
19.50 Telemedicine	0	0	0	0	0	0	19.50
20.00 Total (sum of lines 1-19)	5,176	0	5,176	0	0	0	20.00
21.00 Total cost to be allocated	375,197	0	117,485	0	0	0	21.00
22.00 Unit cost multiplier	72.487828	0.000000	22.698029	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0252  
HHA CCN: 14-7094

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part II  
Date/Time Prepared: 2/27/2019 4:58 pm

Cost Center Description		NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIREMENT)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		(FTE'S NRSING HRS)	(COSTED REQUIS.)					
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	1,065	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	1,065	0	0	0	20.00
21.00	Total cost to be allocated	0	0	406	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.381221	0.000000	0.000000	0.000000	22.00
Cost Center Description		NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS		PARAMED PRGM (ASSIGNED TIME)			
			SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)				
		20.00	21.00	22.00	23.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0252 HHA CCN: 14-7094	Period: From 10/01/2017 To 09/30/2018	Worksheet H-3 Part I Date/Time Prepared: 2/27/2019 4:58 pm		
				Title XVIII	Home Health Agency I	PPS		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	5,065,720		5,065,720	21,947	230.82	1.00
2.00	Physical Therapy	3.00	4,146,896	0	4,146,896	20,515	202.14	2.00
3.00	Occupational Therapy	4.00	808,278	0	808,278	4,460	181.23	3.00
4.00	Speech Pathology	5.00	102,373	0	102,373	661	154.88	4.00
5.00	Medical Social Services	6.00	228,460		228,460	189	1,208.78	5.00
6.00	Home Health Aide	7.00	187,208		187,208	1,603	116.79	6.00
7.00	Total (sum of lines 1-6)		10,538,935	0	10,538,935	49,375		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		16974	0	13,143			8.00
8.01	Skilled Nursing Care		20994	0	94			8.01
8.02	Skilled Nursing Care		29404	0	1,330			8.02
9.00	Physical Therapy		16974	0	12,226			9.00
9.01	Physical Therapy		20994	0	55			9.01
9.02	Physical Therapy		29404	0	1,299			9.02
10.00	Occupational Therapy		16974	0	2,816			10.00
10.01	Occupational Therapy		20994	0	8			10.01
10.02	Occupational Therapy		29404	0	287			10.02
11.00	Speech Pathology		16974	0	392			11.00
11.01	Speech Pathology		20994	0	0			11.01
11.02	Speech Pathology		29404	0	51			11.02
12.00	Medical Social Services		16974	0	124			12.00
12.01	Medical Social Services		20994	0	0			12.01
12.02	Medical Social Services		29404	0	15			12.02
13.00	Home Health Aide		16974	0	926			13.00
13.01	Home Health Aide		20994	0	0			13.01
13.02	Home Health Aide		29404	0	193			13.02
14.00	Total (sum of lines 8-13)			0	32,959			14.00
Cost Center Description								
From Wkst. H-2	Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)		
0		1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	374,749	62,967	437,716	498,300	0.878419	15.00
16.00	Cost of Drugs	9.00	2,216	0	2,216	0	0.000000	16.00
Program Visits								
Cost of Services								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	14,567		0	3,362,355		1.00
2.00	Physical Therapy	0	13,580		0	2,745,061		2.00
3.00	Occupational Therapy	0	3,111		0	563,807		3.00
4.00	Speech Pathology	0	443		0	68,612		4.00
5.00	Medical Social Services	0	139		0	168,020		5.00
6.00	Home Health Aide	0	1,119		0	130,688		6.00
7.00	Total (sum of lines 1-6)	0	32,959		0	7,038,543		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 14-0252 HHA CCN: 14-7094	Period: From 10/01/2017 To 09/30/2018	Worksheet H-3 Part I Date/Time Prepared: 2/27/2019 4:58 pm
				Title XVIII	Home Health Agency I	PPS

Cost Center Description		6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00
Cost Center Description		Program Covered Charges			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	332,627	0	0	292,186	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	3,362,355						1.00
2.00	Physical Therapy	2,745,061						2.00
3.00	Occupational Therapy	563,807						3.00
4.00	Speech Pathology	68,612						4.00
5.00	Medical Social Services	168,020						5.00
6.00	Home Health Aide	130,688						6.00
7.00	Total (sum of lines 1-6)	7,038,543						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0252  
HHA CCN: 14-7094

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet H-3  
Part II  
Date/Time Prepared:  
2/27/2019 4:58 pm

Title XVIII

Home Health  
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>							
1.00 Physical Therapy	66.00	0.343348	0	0	col. 2, line 2.00		1.00
1.01 Physical Therapy 1	66.01	0.425882	0	0	col. 2, line 2.01		1.01
2.00 Occupational Therapy							2.00
3.00 Speech Pathology							3.00
4.00 Cost of Medical Supplies	71.00	0.242795	259,344	62,967	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.266274	0	0	col. 2, line 16.00		5.00
5.01 Cost of Drugs 1	73.01	0.000000	0	0	col. 2, line 16.01		5.01

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0252 HHA CCN: 14-7094	Period: From 10/01/2017 To 09/30/2018	Worksheet H-4 Part I-II Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	176,699	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	4,756,805	0
4.00	Amount 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(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	176,699	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	176,699	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	1,836	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	-1,836
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	6,300,513
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	243,438
13.00	Total PPS Reimbursement - LUPA Episodes		0	96,703
14.00	Total PPS Reimbursement - PEP Episodes		0	54,700
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	46,094
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	165
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	6,739,777
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	6,739,777
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	6,739,777
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	6,739,777
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	6,739,777
31.01	Sequestration adjustment (see instructions)		0	134,833
31.02	Demonstration payment adjustment amount after sequestration		0	0
32.00	Interim payments (see instructions)		0	6,606,838
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	-1,894
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 14-0252  
HHA CCN: 14-7094

Period:  
From 10/01/2017  
To 09/30/2018

Worksheet H-5  
Date/Time Prepared:  
2/27/2019 4:58 pm  
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		0		6,606,838	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			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			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. H-4, Part II, column as appropriate, line 32)		0		6,606,838	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			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		1,894	6.02
7.00	Total Medicare program liability (see instructions)		0		6,604,944	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0252	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/27/2019 4:58 pm
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		6,443,075	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		300,318	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)		219.59	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)		2.37	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		12.87	8.00
9.00	Sum of lines 7 and 8		15.24	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.14	10.00
11.00	Disproportionate share adjustment (see instructions)		202,313	11.00
12.00	Total prospective capital payments (see instructions)		6,945,706	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00