

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: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet S Parts I-III Date/Time Prepared: 12/21/2018 1:44 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: _____ Time: _____
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 PROVIDENT HOSPITAL (14-0300) for the cost reporting period beginning 12/01/2017 and ending 11/30/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	752,480	121,722	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00 Total	0	752,480	121,722	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: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 1:44 pm				
1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 State: IL		4.00 Zip Code: 60615- County: COOK				
1.00 Street: 500 EAST 51ST STREET		2.00 City: CHI CAGO								
Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00		
3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	PROVIDENT HOSPITAL	140300	16974	1	10/08/1993	N	P	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)					12/01/2017	11/30/2018		20.00	
21.00	Type of Control (see instructions)					13			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	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.					N				23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	606	265	0	0	560	0		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 1:44 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		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0	25.00	
						Urban/Rural	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 OPSS 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	XVII	XIX	
						1.00	2.00	3.00	
<u>Prospective Payment System (PPS)-Capital</u>									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	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
<u>Teaching Hospitals</u>									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criteria Code			
				1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)					N		60.00	

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	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 IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
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
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			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 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.							
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
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	76.00

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						1.00			
Long Term Care Hospital PPS									
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N				80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N				81.00		
TEFRA Providers									
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N				85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N				87.00		
						V	XIX		
						1.00	2.00		
Title V and XIX Services									
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.		N		Y		90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		N		91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.		N		N		93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.		N		N		94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.		N		N		96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00		97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		N		N		98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.		Y		Y		98.06		
Rural Providers									
105.00	Does this hospital qualify as a CAH?		N				105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)		N				106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.		N				107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N				108.00		
						Physical	Occupational	Speech	Respiratory
						1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N		N		N	N	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: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 1:44 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	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	3,198,150	137,195	118.01
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet S-2 Part I Date/Time Prepared: 12/21/2018 1:44 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: COOK COUNTY	Contractor's Name:		Contractor's Number: 00131		141.00															
142.00	Street: 118 NORTH CLARK STREET	PO Box:				142.00															
143.00	City: CHI CAGO	State:		Zip Code: 60602		143.00															
144.00 Are provider based physicians' costs included in Worksheet A? 1.00																					
Y																					
144.00 144.00																					
145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.																					
N																					
146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.																					
146.00 146.00																					
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.																					
N																					
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.																					
N																					
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.																					
N																					
149.00 149.00																					
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;"></th> <th style="width:12.5%;">Part A</th> <th style="width:12.5%;">Part B</th> <th style="width:12.5%;">Title V</th> <th style="width:12.5%;">Title XIX</th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> </tr> </thead> </table>									Part A	Part B	Title V	Title XIX		1.00	2.00	3.00	4.00				
	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															
165.00 Multi campus																					
Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.																					
N																					
165.00 165.00																					
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;"></th> <th style="width:12.5%;">Name</th> <th style="width:12.5%;">County</th> <th style="width:12.5%;">State</th> <th style="width:12.5%;">Zip Code</th> <th style="width:12.5%;">CBSA</th> <th style="width:12.5%;">FTE/Campus</th> </tr> <tr> <td></td> <td>0</td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> </tr> </thead> </table>									Name	County	State	Zip Code	CBSA	FTE/Campus		0	1.00	2.00	3.00	4.00	5.00
	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)																					
0.00																					
166.00 166.00																					
Health Information Technology (HIT) Incentive in the American Recovery and Reinvestment Act																					
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.																					
Y																					
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)																					
0																					
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)																					
168.01																					
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)																					
9.99																					
169.00 169.00																					
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:70%;"></th> <th style="width:15%;">Beginning</th> <th style="width:15%;">Ending</th> </tr> <tr> <td></td> <td>1.00</td> <td>2.00</td> </tr> </thead> </table>									Beginning	Ending		1.00	2.00								
	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 09/30/2018																					
170.00 170.00																					
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)																					
N																					
0																					
171.00 171.00																					

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 1:44 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y					3.00
		Y/N	Type				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A				4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					1.00
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	12/03/2018	Y	12/03/2018		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y		Y			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: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet S-2 Part II Date/Time Prepared: 12/21/2018 1:44 pm	
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
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
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	WADE		HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BRADLEY ASSOCIATES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-237-5500		WADEH@BRADLEYCPA.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-2
Part II
Date/Time Prepared:
12/21/2018 1:44 pm

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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-2
Part V
Date/Time Prepared:
12/21/2018 1:44 pm

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name	WADE	1.00
2.00	Last Name	HILL	2.00
3.00	Title	PARTNER	3.00
4.00	Employer	BRADLEY ASSOCIATES	4.00
5.00	Phone Number	(317)237-550	5.00
6.00	E-mail Address	WADEH@BRADLEYCPA.COM	6.00
7.00	Department		7.00
8.00	Mailing Address 1	201 S. CAPITOL AVENUE	8.00
9.00	Mailing Address 2	SUITE 700	9.00
10.00	City	INDIANAPOLIS	10.00
11.00	State	IN	11.00
12.00	Zip	46225	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name	MICHAEL	13.00
14.00	Last Name	SUMRALL	14.00
15.00	Title		15.00
16.00	Employer	COOK COUNTY HEALTH AND HOSPITAL SYST	16.00
17.00	Phone Number	(312)864-4779	17.00
18.00	E-mail Address	MSUMRALL@COOKCOUNTYHHS.ORG	18.00
19.00	Department		19.00
20.00	Mailing Address 1	1340 S. DAMEN STREET	20.00
21.00	Mailing Address 2	SUITE 215	21.00
22.00	City	CHICAGO	22.00
23.00	State	IL	23.00
24.00	Zip	60608	24.00

HFS Supplemental Information		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet S-2 Part IX Date/Time Prepared: 12/21/2018 1:44 pm	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)		Y	Y	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3.01
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00
FQHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	9.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
12/21/2018 1:44 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	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)		25	9,125	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				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: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
12/21/2018 1:44 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	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)	515	871	3,198			1.00
2.00 HMO and other (see instructions)	152	560				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	515	871	3,198			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	515	871	3,198	2.40	374.56	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	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)				2.40	374.56	27.00
28.00 Observation Bed Days		0	250			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00
33.01 LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-3
Part I
Date/Time Prepared:
12/21/2018 1:44 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	102	140	582	1.00
2.00 HMO and other (see instructions)				28	124		2.00
3.00 HMO IPF Subprovider					0		3.00
4.00 HMO IRF Subprovider					0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0		102	140	582	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF							17.00
18.00 SUBPROVIDER							18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						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: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-3
Part II
Date/Time Prepared:
12/21/2018 1:44 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	31,503,620	3,081,556	34,585,176	779,094.00	44.39
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		1,493,378	0	1,493,378	9,923.00	150.50
4.01	Physicians - Part A - Teaching		71,844	0	71,844	477.00	150.62
5.00	Physician and Non-Physician-Part B		7,668,643	0	7,668,643	66,969.00	114.51
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	13,622	13,622	171.00	79.66
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)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		466,355	0	466,355	7,323.00	63.68
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		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		4,738,876	0	4,738,876	122,185.00	38.78
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		6,456,621	0	6,456,621		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		0	0	0		
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		373,296	0	373,296		
22.01	Physician Part A - Teaching		17,959	0	17,959		
23.00	Physician Part B		2,040,417	0	2,040,417		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		3,441	0	3,441		
25.50	Home office wage-related (core)		898,276	0	898,276		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	884,800	0	884,800	4,168.00	212.28
27.00	Administrative & General	5.00	2,323,814	0	2,323,814	56,377.00	41.22

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-3
Part II
Date/Time Prepared:
12/21/2018 1:44 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.)	42,102	0	42,102	795.00	52.96	28.00
29.00	Maintenance & Repairs	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	1,739,856	0	1,739,856	39,281.00	44.29	30.00
31.00	Laundry & Linen Service	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	1,126,637	0	1,126,637	52,687.00	21.38	32.00
33.00	Housekeeping under contract (see instructions)	0	0	0	0.00	0.00	33.00
34.00	Dietary	0	0	0	0.00	0.00	34.00
35.00	Dietary under contract (see instructions)	74,077	0	74,077	3,221.00	23.00	35.00
36.00	Cafeteria	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	1,026,969	0	1,026,969	33,627.00	30.54	38.00
39.00	Central Services and Supply	225,577	0	225,577	9,208.00	24.50	39.00
40.00	Pharmacy	2,671,815	0	2,671,815	60,507.00	44.16	40.00
41.00	Medical Records & Medical Records Library	170,763	0	170,763	5,272.00	32.39	41.00
42.00	Social Service	34,717	0	34,717	2,138.00	16.24	42.00
43.00	Other General Service	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet S-3
Part III
Date/Time Prepared:
12/21/2018 1:44 pm

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	23,879,312	3,067,934	26,947,246	715,493.00	37.66	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	23,879,312	3,067,934	26,947,246	715,493.00	37.66	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,205,231	0	5,205,231	129,508.00	40.19	4.00
5.00	Subtotal wage-related costs (see inst.)	7,728,193	0	7,728,193	0.00	28.68	5.00
6.00	Total (sum of lines 3 thru 5)	36,812,736	3,067,934	39,880,670	845,001.00	47.20	6.00
7.00	Total overhead cost (see instructions)	10,321,127	0	10,321,127	267,281.00	38.62	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet S-3 Part IV Date/Time Prepared: 12/21/2018 1:44 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 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)			2,846,403 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)			0 8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)			3,548,923 8.02
8.03	Health Insurance (Purchased)			0 8.03
9.00	Prescription Drug Plan			1,298,229 9.00
10.00	Dental, Hearing and Vision Plan			182,863 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			49,661 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)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			445,949 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			357,637 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			162,069 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			8,891,734 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet S-3 Part V Date/Time Prepared: 12/21/2018 1:44 pm
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		466,355	8,891,734
2.00	Hospital		466,355	6,456,621
3.00	Subprovider - IPF			
4.00	Subprovider - IRF			
5.00	Subprovider - (Other)		0	0
6.00	Swing Beds - SNF		0	0
7.00	Swing Beds - NF		0	0
8.00	Hospital-Based SNF			
9.00	Hospital-Based NF			
10.00	Hospital-Based OLTC			
11.00	Hospital-Based HHA			
12.00	Separately Certified ASC			
13.00	Hospital-Based Hospice			
14.00	Hospital-Based Health Clinic RHC		0	0
15.00	Hospital-Based Health Clinic FQHC		0	0
16.00	Hospital-Based-CMHC			
16.10	Hospital-Based-CMHC 10		0	0
17.00	Renal Dialysis		0	0
18.00	Other		0	2,435,113

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet S-10 Date/Time Prepared: 12/21/2018 1:44 pm
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.622042	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		5,050,382	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		15,485,034	6.00	
7.00	Medicaid cost (line 1 times line 6)		9,632,342	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)		4,581,960	8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP		33,210	9.00	
10.00	Stand-alone CHIP charges		37,943	10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)		23,602	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)		41,927	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		35,009	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		21,777	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)		4,581,960	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)	34,005,992	0	34,005,992	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	21,153,155	0	21,153,155	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)	21,153,155	0	21,153,155	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)		13,239,620		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		204,159		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		314,090		27.01
28.00	Non-Medicare bad debt expense (see instructions)		12,925,530		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		8,150,154		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		29,303,309		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		33,885,269		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A
Date/Time Prepared:
12/21/2018 1:44 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	
GENERAL SERVICE COST CENTERS							
1.00	00100		1,049,507	1,049,507	0	1,049,507	1.00
2.00	00200		399,124	399,124	0	399,124	2.00
4.00	00400	884,800	5,367,057	6,251,857	0	6,251,857	4.00
5.00	00500	2,323,814	3,553,782	5,877,596	0	5,877,596	5.00
6.00	00600	0	0	0	0	0	6.00
7.00	00700	1,739,856	4,599,165	6,339,021	0	6,339,021	7.00
8.00	00800	0	87,273	87,273	0	87,273	8.00
9.00	00900	1,126,637	57,190	1,183,827	0	1,183,827	9.00
10.00	01000	0	1,123,636	1,123,636	-1,053,640	69,996	10.00
11.00	01100	0	0	0	1,053,640	1,053,640	11.00
13.00	01300	1,026,969	324,596	1,351,565	0	1,351,565	13.00
14.00	01400	225,577	899,397	1,124,974	0	1,124,974	14.00
15.00	01500	2,671,815	29	2,671,844	0	2,671,844	15.00
16.00	01600	170,763	0	170,763	0	170,763	16.00
17.00	01700	34,717	136,927	171,644	0	171,644	17.00
21.00	02100	0	0	0	13,622	13,622	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	3,875,901	0	3,875,901	-13,622	3,862,279	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	3,689,375	0	3,689,375	0	3,689,375	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	686,780	0	686,780	0	686,780	53.00
54.00	05400	1,467,161	158	1,467,319	0	1,467,319	54.00
60.00	06000	1,613,071	82,893	1,695,964	0	1,695,964	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	30,120	0	30,120	0	30,120	62.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	995,739	793	996,532	0	996,532	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	772,010	932	772,942	0	772,942	69.00
71.00	07100	0	1,308,656	1,308,656	0	1,308,656	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	428,634	428,634	0	428,634	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	117,615	0	117,615	0	117,615	90.00
91.00	09100	8,050,900	935,138	8,986,038	0	8,986,038	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		31,503,620	20,354,887	51,858,507	0	51,858,507	118.00
NONREIMBURSABLE COST CENTERS							
200.00		31,503,620	20,354,887	51,858,507	0	51,858,507	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,027,606	3,077,113	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	884,326	1,283,450	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,552,224	9,804,081	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,033,026	20,910,622	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	6,339,021	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	87,273	8.00
9.00	00900	HOUSEKEEPING	0	1,183,827	9.00
10.00	01000	DIETARY	0	69,996	10.00
11.00	01100	CAFETERIA	0	1,053,640	11.00
13.00	01300	NURSING ADMINISTRATION	14,989	1,366,554	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,124,974	14.00
15.00	01500	PHARMACY	-240,665	2,431,179	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	170,763	16.00
17.00	01700	SOCIAL SERVICE	0	171,644	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A	0	13,622	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,217,043	2,645,236	30.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,607,250	1,082,125	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	686,780	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-336,223	1,131,096	54.00
60.00	06000	LABORATORY	-208,963	1,487,001	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	30,120	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	996,532	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	772,942	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	1,308,656	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	208,525	637,159	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	3,134,476	3,252,091	90.00
91.00	09100	EMERGENCY	-4,016,822	4,969,216	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	16,228,206	68,086,713	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118 through 199)	16,228,206	68,086,713	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet Non-CMS W
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
	1.00	2.00	
GENERAL SERVICE COST CENTERS			
1.00 CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00 ADMINISTRATIVE & GENERAL	00500		5.00
6.00 MAINTENANCE & REPAIRS	00600		6.00
7.00 OPERATION OF PLANT	00700		7.00
8.00 LAUNDRY & LINEN SERVICE	00800		8.00
9.00 HOUSEKEEPING	00900		9.00
10.00 DIETARY	01000		10.00
11.00 CAFETERIA	01100		11.00
13.00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15.00 PHARMACY	01500		15.00
16.00 MEDICAL RECORDS & LIBRARY	01600		16.00
17.00 SOCIAL SERVICE	01700		17.00
21.00 I&R SERVICES-SALARY & FRINGES A	02100		21.00
22.00 I&R SERVICES-OTHER PRGM COSTS A	02200		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00 ADULTS & PEDIATRICS	03000		30.00
43.00 NURSERY	04300		43.00
ANCILLARY SERVICE COST CENTERS			
50.00 OPERATING ROOM	05000		50.00
51.00 RECOVERY ROOM	05100		51.00
52.00 DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00 ANESTHESIOLOGY	05300		53.00
54.00 RADIOLOGY-DIAGNOSTIC	05400		54.00
60.00 LABORATORY	06000		60.00
60.01 BLOOD LABORATORY	06001		60.01
62.00 WHOLE BLOOD & PACKED RED BLOOD	06200		62.00
65.00 RESPIRATORY THERAPY	06500		65.00
66.00 PHYSICAL THERAPY	06600		66.00
67.00 OCCUPATIONAL THERAPY	06700		67.00
68.00 SPEECH PATHOLOGY	06800		68.00
69.00 ELECTROCARDIOLOGY	06900		69.00
71.00 MEDICAL SUPPLIES CHARGED TO PAT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
74.00 RENAL DIALYSIS	07400		74.00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	08800		88.00
89.00 FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00 CLINIC	09000		90.00
91.00 EMERGENCY	09100		91.00
92.00 OBSERVATION BEDS (NON-DISTINCT	09200		92.00
OTHER REIMBURSABLE COST CENTERS			
99.10 CORF	09910		99.10
SPECIAL PURPOSE COST CENTERS			
109.00 PANCREAS ACQUISITION	10900		109.00
110.00 INTESTINAL ACQUISITION	11000		110.00
111.00 ISLET ACQUISITION	11100		111.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS			
200.00 TOTAL (SUM OF LINES 118 through 199)			200.00

		Increases			
		Cost Center	Line #	Salary	Other
		2.00	3.00	4.00	5.00
A - Cafeteria					
1.00	CAFETERIA		11.00	0	1,053,640
	TOTALS			0	1,053,640
B - Interns & Residents					
1.00	I&R SERVICES-SALARY & FRINGES A		21.00	13,622	
				13,622	0
C - Sengstacke Salaries					
1.00	CLINIC		90.00	3,081,556	
				3,081,556	0
500.00	Grand Total: Increases			3,095,178	1,053,640

RECLASSIFICATIONS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-6

Date/Time Prepared:
12/21/2018 1:44 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - Cafeteria						
1.00	DIETARY	10.00	0	1,053,640	0	1.00
	TOTALS		0	1,053,640		
B - Interns & Residents						
1.00	ADULTS & PEDIATRICS	30.00	13,622			1.00
			13,622	0		
C - Sengstacke Salaries						
1.00	CLINIC	90.00		3,081,556		1.00
			0	3,081,556		
500.00	Grand Total: Decreases		13,622	4,135,196		500.00

Increases					Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
A - Cafeteria									
1.00	CAFETERIA	11.00	0	1,053,640	DIETARY	10.00	0	1,053,640	1.00
	TOTALS		0	1,053,640	TOTALS		0	1,053,640	
B - Interns & Residents									
1.00	I&R SERVICES-SALARY & FRINGES A	21.00	13,622	0	ADULTS & PEDIATRICS	30.00	13,622	0	1.00
			13,622	0			13,622	0	
C - Sengstacke Salaries									
1.00	CLINIC	90.00	3,081,556	0	CLINIC	90.00	0	3,081,556	1.00
			3,081,556	0			0	3,081,556	
500.00	Grand Total:		3,095,178	1,053,640	Grand Total:		13,622	4,135,196	500.00
	Increases				Decreases				

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-7
Part I
Date/Time Prepared:
12/21/2018 1:44 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	51,185,909	1,342,035	0	1,342,035	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	505,260	0	0	0	0	5.00
6.00	Movable Equipment	13,421,929	78,692	0	78,692	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	65,113,098	1,420,727	0	1,420,727	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	65,113,098	1,420,727	0	1,420,727	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	52,527,944	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	505,260	0				5.00
6.00	Movable Equipment	13,500,621	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	66,533,825	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	66,533,825	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-7
Part II
Date/Time Prepared:
12/21/2018 1:44 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	1,048,921	586	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	208,183	190,941	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,257,104	191,527	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	1,049,507				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	399,124				2.00
3.00	Total (sum of lines 1-2)	0	1,448,631				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-7
Part III
Date/Time Prepared:
12/21/2018 1:44 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	53,033,204	0	53,033,204	0.797086	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,500,621	0	13,500,621	0.202914	0	2.00
3.00	Total (sum of lines 1-2)	66,533,825	0	66,533,825	1.000000	0	3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL			
	Taxes	Other Capital-Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease		
	6.00	7.00	8.00	9.00	10.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1,048,921	586	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	208,183	190,941	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,257,104	191,527	3.00
Cost Center Description	SUMMARY OF CAPITAL						
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)		
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	2,027,606	0	0	0	3,077,113	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	884,326	0	0	0	1,283,450	2.00
3.00	Total (sum of lines 1-2)	2,911,932	0	0	0	4,360,563	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8

Date/Time Prepared:
12/21/2018 1:44 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	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-3,320	CAP REL COSTS-BLDG & FIXT		1.00	11 1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 2.00
3.00 Investment income - other (chapter 2)		0			0.00	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0 6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	0 7.00
8.00 Television and radio service (chapter 21)		0			0.00	0 8.00
9.00 Parking lot (chapter 21)	B	-113,951	ADMINISTRATIVE & GENERAL		5.00	0 9.00
10.00 Provider-based physician adjustment	A-8-2	-7,943,789				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	11,359,015				0 12.00
13.00 Laundry and linen service		0			0.00	0 13.00
14.00 Cafeteria-employees and guests		0			0.00	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	B	-240,665	PHARMACY		15.00	0 17.00
18.00 Sale of medical records and abstracts		0			0.00	0 18.00
19.00 Nursing and allied health education (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY		66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***		114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT		1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP		2.00	0 27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***		19.00	28.00
29.00 Physicians' assistant		0			0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY		67.00	30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS		30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	0 32.00
33.00 Misc. Income - Debit balance	B	17,093	ADMINISTRATIVE & GENERAL		5.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8

Date/Time Prepared:
12/21/2018 1:44 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		
33.01 Sengstacke Cost from Stroger	A	678,274	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02 Sengstacke Cost from Stroger	A	-10,795	DRUGS CHARGED TO PATIENTS	73.00	0	33.02
33.03 Sengstacke Cost from Stroger	A	3,134,476	CLINIC	90.00	0	33.03
33.04 Added Interest Capital	A	2,030,926	CAP REL COSTS-BLDG & FIXT	1.00	11	33.04
33.05 Added Interest Mvbl Equip Capital	A	884,326	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.05
33.06 Added Interest Working Capital	A	733,125	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 Lobbying Dues	A	-6,996	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08 Insurance Adjustment	A	3,335,345	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 Physicians' assistant	A	-237,096	OPERATING ROOM	50.00	0	33.09
33.10 Physicians' assistant	A	-234,164	EMERGENCY	91.00	0	33.10
33.11 PENSION COST	A	2,846,402	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		16,228,206				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8-1

Date/Time Prepared:
12/21/2018 1:44 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	Bureau of Health Allocated C	8,791,734	0 1.00
2.00	73.00	DRUGS CHARGED TO PATIENTS	Bureau of Health Allocated C	219,320	0 2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	Bureau of Health Allocated C	27,548	0 3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	Cook County Allocated Cost	2,305,424	0 3.01
3.02	13.00	NURSING ADMINISTRATION	Bureau of Health Allocated C	14,989	0 3.02
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4).			11,359,015	0 5.00
Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

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

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

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

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

6.00	G	Cook County	100.00	Cook County	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	County Govt.				100.00

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

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

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

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8-1

Date/Time Prepared:
12/21/2018 1:44 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	8,791,734	0		1.00
2.00	219,320	0		2.00
3.00	27,548	0		3.00
3.01	2,305,424	0		3.01
3.02	14,989	0		3.02
4.00	0	0		4.00
5.00	11,359,015			5.00

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

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

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

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

6.00	Government		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet A-8-2

Date/Time Prepared:
12/21/2018 1:44 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	5.00	ADMINISTRATIVE & GENERAL	264,250	0	264,250	179,000	2,080	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,454,851	1,179,817	275,034	179,000	2,080	2.00
3.00	50.00	OPERATING ROOM	2,680,848	2,347,416	333,432	239,400	2,080	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	336,223	336,223	0	0	0	5.00
6.00	60.00	LABORATORY	208,963	208,963	0	0	0	6.00
7.00	91.00	EMERGENCY	4,288,729	3,596,223	692,506	179,000	4,160	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			9,233,864	7,668,642	1,565,222		10,400	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	179,000	8,950	0	0	56,502	1.00
2.00	30.00	ADULTS & PEDIATRICS	179,000	8,950	0	0	311,075	2.00
3.00	50.00	OPERATING ROOM	239,400	11,970	0	0	573,217	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	71,891	5.00
6.00	60.00	LABORATORY	0	0	0	0	44,680	6.00
7.00	91.00	EMERGENCY	358,000	17,900	0	0	917,014	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			955,400	47,770	0	0	1,974,379	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	56,502	235,502	28,748	28,748	1.00
2.00	30.00	ADULTS & PEDIATRICS	58,808	237,808	37,226	1,217,043	2.00
3.00	50.00	OPERATING ROOM	71,294	310,694	22,738	2,370,154	3.00
4.00	0.00		0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	336,223	5.00
6.00	60.00	LABORATORY	0	0	0	208,963	6.00
7.00	91.00	EMERGENCY	148,071	506,071	186,435	3,782,658	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			334,675	1,290,075	275,147	7,943,789	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	3,077,113	3,077,113			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,283,450		1,283,450		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,804,081	31,401	0	9,835,482	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	20,910,622	591,861	276,681	678,207	22,457,371 5.00
6.00 00600	MAINTENANCE & REPAIRS	0	10,347	31,225	0	41,572 6.00
7.00 00700	OPERATION OF PLANT	6,339,021	461,004	129,346	507,779	7,437,150 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	87,273	0	0	0	87,273 8.00
9.00 00900	HOUSEKEEPING	1,183,827	8,956	14,328	328,810	1,535,921 9.00
10.00 01000	DIETARY	69,996	99,504	0	0	169,500 10.00
11.00 01100	CAFETERIA	1,053,640	44,675	0	0	1,098,315 11.00
13.00 01300	NURSING ADMINISTRATION	1,366,554	21,238	75,897	299,722	1,763,411 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	1,124,974	14,401	9,650	65,835	1,214,860 14.00
15.00 01500	PHARMACY	2,431,179	19,263	4,065	779,772	3,234,279 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	170,763	68,535	0	49,837	289,135 16.00
17.00 01700	SOCIAL SERVICE	171,644	9,699	0	10,132	191,475 17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A	13,622	0	0	3,976	17,598 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	2,645,236	342,556	158,681	1,127,210	4,273,683 30.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,082,125	185,423	138,182	1,076,748	2,482,478 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0 52.00
53.00 05300	ANESTHESIOLOGY	686,780	52,719	0	200,437	939,936 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,131,096	205,782	341,295	428,192	2,106,365 54.00
60.00 06000	LABORATORY	1,487,001	157,013	15,645	470,776	2,130,435 60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0 60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD	30,120	6,285	1,235	8,791	46,431 62.00
65.00 06500	RESPIRATORY THERAPY	0	0	31,171	0	31,171 65.00
66.00 06600	PHYSICAL THERAPY	996,532	45,522	8,168	290,607	1,340,829 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	22,189	0	0	22,189 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	772,942	14,177	41,206	225,312	1,053,637 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	1,308,656	0	0	0	1,308,656 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	637,159	0	0	0	637,159 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0 89.00
90.00 09000	CLINIC	3,252,091	486,168	4,278	933,681	4,676,218 90.00
91.00 09100	EMERGENCY	4,969,216	178,395	2,397	2,349,658	7,499,666 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0 99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0 111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	68,086,713	3,077,113	1,283,450	9,835,482	68,086,713 118.00
NONREIMBURSABLE COST CENTERS						
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)	68,086,713	3,077,113	1,283,450	9,835,482	68,086,713 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B
Part I
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,457,371				5.00
6.00	00600	MAINTENANCE & REPAIRS	20,460	62,032			6.00
7.00	00700	OPERATION OF PLANT	3,660,342	11,703	11,109,195		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	42,953	0	0	130,226	8.00
9.00	00900	HOUSEKEEPING	755,934	227	50,185	6,056	2,348,323
10.00	01000	DIETARY	83,423	2,526	557,586	0	0
11.00	01100	CAFETERIA	540,558	1,134	250,340	0	0
13.00	01300	NURSING ADMINISTRATION	867,898	539	119,009	0	387,247
14.00	01400	CENTRAL SERVICES & SUPPLY	597,918	366	80,699	109	27,632
15.00	01500	PHARMACY	1,591,815	489	107,942	0	19,118
16.00	01600	MEDICAL RECORDS & LIBRARY	142,304	1,740	384,046	0	0
17.00	01700	SOCIAL SERVICE	94,238	246	54,352	0	13,542
21.00	02100	I&R SERVICES-SALARY & FRINGES A	8,661	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,103,379	8,696	1,919,558	80,492	943,920
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,221,801	4,707	1,039,044	12,131	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	462,608	1,338	295,417	29	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,036,690	5,224	1,153,124	138	95,691
60.00	06000	LABORATORY	1,048,536	3,986	879,842	159	24,047
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	22,852	160	35,219	16	11,999
65.00	06500	RESPIRATORY THERAPY	15,341	0	0	0	0
66.00	06600	PHYSICAL THERAPY	659,916	1,156	255,090	76	10,107
67.00	06700	OCCUPATIONAL THERAPY	10,921	563	124,341	4	4,033
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	518,569	360	79,444	25	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	644,081	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	313,591	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	2,301,494	12,343	2,724,299	17	0
91.00	09100	EMERGENCY	3,691,088	4,529	999,658	30,974	810,987
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,457,371	62,032	11,109,195	130,226	2,348,323
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	22,457,371	62,032	11,109,195	130,226	2,348,323

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
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	813,035					10.00
11.00	01100	0	1,890,347				11.00
13.00	01300	0	71,739	3,209,843			13.00
14.00	01400	0	0	0	1,921,584		14.00
15.00	01500	0	0	0	384,042	5,337,685	15.00
16.00	01600	0	85,994	0	0	0	16.00
17.00	01700	0	26,902	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	672,094	938,830	1,008,170	412	1,429	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	158,875	801,081	95,696	332,216	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	123,238	0	17,727	61,540	54.00
60.00	06000	0	118,480	0	224,131	778,088	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	15,841	0	0	0	62.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	77,915	0	25,289	87,794	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	16,031	0	322	1,119	69.00
71.00	07100	0	0	0	1,154,293	4,007,207	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	19,672	68,292	90.00
91.00	09100	140,941	256,502	1,400,592	0	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		813,035	1,890,347	3,209,843	1,921,584	5,337,685	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		813,035	1,890,347	3,209,843	1,921,584	5,337,685	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B
Part I
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	903,219				16.00
17.00 01700	SOCIAL SERVICE	73	380,828			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	26,259		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	47,704	176,091	16,564	0	30.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	4,466	0	3,305	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	2,392	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	110	0	0	0	54.00
60.00 06000	LABORATORY	329	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	511,963	204,737	0	0	90.00
91.00 09100	EMERGENCY	338,574	0	3,998	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	903,219	380,828	26,259	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments			0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	903,219	380,828	26,259	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-16,564	12,174,458
43.00	04300	NURSERY	0	0
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-3,305	6,152,495
51.00	05100	RECOVERY ROOM	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0
53.00	05300	ANESTHESIOLOGY	-2,392	1,699,328
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,599,847
60.00	06000	LABORATORY	0	5,208,033
60.01	06001	BLOOD LABORATORY	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	132,518
65.00	06500	RESPIRATORY THERAPY	0	46,512
66.00	06600	PHYSICAL THERAPY	0	2,458,172
67.00	06700	OCCUPATIONAL THERAPY	0	162,051
68.00	06800	SPEECH PATHOLOGY	0	0
69.00	06900	ELECTROCARDIOLOGY	0	1,669,507
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	7,114,237
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	950,750
74.00	07400	RENAL DIALYSIS	0	0
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0
90.00	09000	CLINIC	0	10,519,035
91.00	09100	EMERGENCY	-3,998	15,173,511
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0
111.00	11100	ISLET ACQUISITION	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-26,259	68,060,454
NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118 through 201)	-26,259	68,060,454

COST ALLOCATION STATISTICS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet Non-CMS W
Date/Time Prepared:
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Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	1	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	4	HOURS OF SERVICE	9.00
10.00	DIETARY	5	MEALS SERVED	10.00
11.00	CAFETERIA	6	MEALS SERVED	11.00
13.00	NURSING ADMINISTRATION	7	DIRECT NRSING	13.00
14.00	CENTRAL SERVICES & SUPPLY	8	COSTED REQUIS.	14.00
15.00	PHARMACY	8	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	9	TIME SPENT	16.00
17.00	SOCIAL SERVICE	10	TIME SPENT	17.00
21.00	I&R SERVICES-SALARY & FRINGES A	11	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS A	12	ASSIGNED TIME	22.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B
Part II
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	31,401	0	31,401	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	949,658	591,861	276,681	1,818,200	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	10,347	31,225	41,572	6.00
7.00 00700	OPERATION OF PLANT	0	461,004	129,346	590,350	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	8,956	14,328	23,284	9.00
10.00 01000	DIETARY	0	99,504	0	99,504	10.00
11.00 01100	CAFETERIA	0	44,675	0	44,675	11.00
13.00 01300	NURSING ADMINISTRATION	0	21,238	75,897	97,135	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	14,401	9,650	24,051	14.00
15.00 01500	PHARMACY	0	19,263	4,065	23,328	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	68,535	0	68,535	16.00
17.00 01700	SOCIAL SERVICE	0	9,699	0	9,699	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	342,556	158,681	501,237	30.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	185,423	138,182	323,605	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	52,719	0	52,719	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	205,782	341,295	547,077	54.00
60.00 06000	LABORATORY	0	157,013	15,645	172,658	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD	0	6,285	1,235	7,520	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	31,171	31,171	65.00
66.00 06600	PHYSICAL THERAPY	0	45,522	8,168	53,690	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	22,189	0	22,189	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	14,177	41,206	55,383	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	486,168	4,278	490,446	90.00
91.00 09100	EMERGENCY	0	178,395	2,397	180,792	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	949,658	3,077,113	1,283,450	5,310,221	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	949,658	3,077,113	1,283,450	5,310,221	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet B Part II Date/Time Prepared: 12/21/2018 1:44 pm		
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING
		5.00	6.00	7.00	8.00	9.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,820,366			5.00
6.00	00600	MAINTENANCE & REPAIRS	1,659	43,231		6.00
7.00	00700	OPERATION OF PLANT	296,705	8,156	896,833	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,482	0	0	3,482
9.00	00900	HOUSEKEEPING	61,276	158	4,051	162
10.00	01000	DIETARY	6,762	1,760	45,013	0
11.00	01100	CAFETERIA	43,817	790	20,210	0
13.00	01300	NURSING ADMINISTRATION	70,351	376	9,607	0
14.00	01400	CENTRAL SERVICES & SUPPLY	48,467	255	6,515	3
15.00	01500	PHARMACY	129,032	341	8,714	0
16.00	01600	MEDICAL RECORDS & LIBRARY	11,535	1,213	31,004	0
17.00	01700	SOCIAL SERVICE	7,639	172	4,388	0
21.00	02100	I&R SERVICES-SALARY & FRINGES A	702	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	170,499	6,061	154,964	2,153
43.00	04300	NURSERY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	99,038	3,281	83,881	324
51.00	05100	RECOVERY ROOM	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	37,499	933	23,849	1
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,033	3,641	93,090	4
60.00	06000	LABORATORY	84,994	2,778	71,029	4
60.01	06001	BLOOD LABORATORY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1,852	111	2,843	0
65.00	06500	RESPIRATORY THERAPY	1,244	0	0	0
66.00	06600	PHYSICAL THERAPY	53,492	805	20,593	2
67.00	06700	OCCUPATIONAL THERAPY	885	393	10,038	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	42,035	251	6,413	1
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	52,209	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	25,419	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
90.00	09000	CLINIC	186,558	8,600	219,930	0
91.00	09100	EMERGENCY	299,182	3,156	80,701	828
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)				31,075
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,820,366	43,231	896,833	3,482
NONREIMBURSABLE COST CENTERS						
200.00		Cross Foot Adjustments				
201.00		Negative Cost Centers	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	1,820,366	43,231	896,833	3,482

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
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	153,039					10.00
11.00	01100	0	109,492				11.00
13.00	01300	0	4,155	197,419			13.00
14.00	01400	0	0	0	80,560		14.00
15.00	01500	0	0	0	16,101	180,739	15.00
16.00	01600	0	4,981	0	0	0	16.00
17.00	01700	0	1,558	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	126,509	54,378	62,007	17	48	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	9,202	49,270	4,012	11,249	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	7,138	0	743	2,084	54.00
60.00	06000	0	6,863	0	9,396	26,347	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	918	0	0	0	62.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	0	4,513	0	1,060	2,973	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	929	0	14	38	69.00
71.00	07100	0	0	0	48,392	135,688	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	825	2,312	90.00
91.00	09100	26,530	14,857	86,142	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		153,039	109,492	197,419	80,560	180,739	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		153,039	109,492	197,419	80,560	180,739	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B
Part II
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES A	SERVICES-OTHER PRGM COSTS A		
			16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	117,427				16.00
17.00 01700	SOCIAL SERVICE	10	24,017			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	715		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	6,202	11,105			30.00
43.00 04300	NURSERY	0	0			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	581	0			50.00
51.00 05100	RECOVERY ROOM	0	0			51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00 05300	ANESTHESIOLOGY	0	0		115,641	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	14	0		742,858	54.00
60.00 06000	LABORATORY	43	0		376,536	60.00
60.01 06001	BLOOD LABORATORY	0	0		0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD	0	0		13,732	62.00
65.00 06500	RESPIRATORY THERAPY	0	0		32,415	65.00
66.00 06600	PHYSICAL THERAPY	0	0		138,443	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0		33,660	67.00
68.00 06800	SPEECH PATHOLOGY	0	0		0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0		105,784	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0		236,289	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0		25,419	73.00
74.00 07400	RENAL DIALYSIS	0	0		0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0			88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00 09000	CLINIC	66,559	12,912			90.00
91.00 09100	EMERGENCY	44,018	0			91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0			99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0			109.00
110.00 11000	INTESTINAL ACQUISITION	0	0			110.00
111.00 11100	ISLET ACQUISITION	0	0			111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	117,427	24,017	0	0	118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments			715	0	200.00
201.00	Negative Cost Centers	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	117,427	24,017	715	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B
Part II
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES A		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS A		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	118.00
NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
12/21/2018 1:44 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				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	384,823				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		1,293,836			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,927	0	33,700,376		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	74,018	278,920	2,323,814	-22,457,371	45,629,342
6.00 00600	MAINTENANCE & REPAIRS	1,294	31,478	0	0	41,572
7.00 00700	OPERATION OF PLANT	57,653	130,393	1,739,856	0	7,437,150
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	87,273
9.00 00900	HOUSEKEEPING	1,120	14,444	1,126,637	0	1,535,921
10.00 01000	DIETARY	12,444	0	0	0	169,500
11.00 01100	CAFETERIA	5,587	0	0	0	1,098,315
13.00 01300	NURSING ADMINISTRATION	2,656	76,511	1,026,969	0	1,763,411
14.00 01400	CENTRAL SERVICES & SUPPLY	1,801	9,728	225,577	0	1,214,860
15.00 01500	PHARMACY	2,409	4,098	2,671,815	0	3,234,279
16.00 01600	MEDICAL RECORDS & LIBRARY	8,571	0	170,763	0	289,135
17.00 01700	SOCIAL SERVICE	1,213	0	34,717	0	191,475
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	0	13,622	0	17,598
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	42,840	159,965	3,862,279	0	4,273,683
43.00 04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	23,189	139,300	3,689,375	0	2,482,478
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	6,593	0	686,780	0	939,936
54.00 05400	RADIOLOGY-DIAGNOSTIC	25,735	344,057	1,467,161	0	2,106,365
60.00 06000	LABORATORY	19,636	15,772	1,613,071	0	2,130,435
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD	786	1,245	30,120	0	46,431
65.00 06500	RESPIRATORY THERAPY	0	31,423	0	0	31,171
66.00 06600	PHYSICAL THERAPY	5,693	8,234	995,739	0	1,340,829
67.00 06700	OCCUPATIONAL THERAPY	2,775	0	0	0	22,189
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	1,773	41,539	772,010	0	1,053,637
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	1,308,656
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	637,159
74.00 07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	60,800	4,313	3,199,171	0	4,676,218
91.00 09100	EMERGENCY	22,310	2,416	8,050,900	0	7,499,666
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)					
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	384,823	1,293,836	33,700,376	-22,457,371	45,629,342
NONREIMBURSABLE COST CENTERS						
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)	3,077,113	1,283,450	9,835,482		22,457,371
203.00	Unit cost multiplier (Wkst. B, Part I)	7.996177	0.991973	0.291851		0.492170
204.00	Cost to be allocated (per Wkst. B, Part II)			31,401		1,820,366
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000932		0.039895
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	305,584					6.00
7.00	00700	57,653	247,931				7.00
8.00	00800	0	0	486,312			8.00
9.00	00900	1,120	1,120	22,614	47,167		9.00
10.00	01000	12,444	12,444	0	0	21,142	10.00
11.00	01100	5,587	5,587	0	0	0	11.00
13.00	01300	2,656	2,656	0	7,778	0	13.00
14.00	01400	1,801	1,801	407	555	0	14.00
15.00	01500	2,409	2,409	0	384	0	15.00
16.00	01600	8,571	8,571	0	0	0	16.00
17.00	01700	1,213	1,213	0	272	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	42,840	42,840	300,588	18,959	17,477	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	23,189	23,189	45,300	0	0	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	6,593	6,593	110	0	0	53.00
54.00	05400	25,735	25,735	516	1,922	0	54.00
60.00	06000	19,636	19,636	594	483	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	786	786	61	241	0	62.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	5,693	5,693	282	203	0	66.00
67.00	06700	2,775	2,775	16	81	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,773	1,773	94	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	60,800	60,800	62	0	0	90.00
91.00	09100	22,310	22,310	115,668	16,289	3,665	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		305,584	247,931	486,312	47,167	21,142	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		62,032	11,109,195	130,226	2,348,323	813,035	202.00
203.00		0.202995	44.807608	0.267783	49.787415	38.455917	203.00
204.00		43,231	896,833	3,482	89,981	153,039	204.00
205.00		0.141470	3.617269	0.007160	1.907711	7.238625	205.00
206.00							206.00
207.00							207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1

Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	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	89,380					11.00
13.00	01300	3,392	143,110				13.00
14.00	01400	0	0	2,068,042			14.00
15.00	01500	0	0	413,313	1,654,729		15.00
16.00	01600	4,066	0	0	0	24,671	16.00
17.00	01700	1,272	0	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,390	44,949	443	443	1,303	30.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,512	35,716	102,990	102,990	122	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	5,827	0	19,078	19,078	3	54.00
60.00	06000	5,602	0	241,214	241,214	9	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	749	0	0	0	0	62.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	3,684	0	27,217	27,217	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	758	0	347	347	0	69.00
71.00	07100	0	0	1,242,269	1,242,269	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	21,171	21,171	13,984	90.00
91.00	09100	12,128	62,445	0	0	9,248	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		89,380	143,110	2,068,042	1,654,729	24,671	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,890,347	3,209,843	1,921,584	5,337,685	903,219	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	21.149552	22.429201	0.929180	3.225716	36.610555	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	109,492	197,419	80,560	180,739	117,427	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.225017	1.379491	0.038955	0.109226	4.759718	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: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet B-1
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS			
		SERVICES-SALARY & FRINGES A (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS A (ASSIGNED TIME)		
		17.00	21.00		
GENERAL SERVICE COST CENTERS					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE	7,671			17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES A	0	8,946		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS A	0		0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	3,547	5,643	0	30.00
43.00 04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	1,126	0	50.00
51.00 05100	RECOVERY ROOM	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	815	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00 06000	LABORATORY	0	0	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	62.00
65.00 06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000	CLINIC	4,124	0	0	90.00
91.00 09100	EMERGENCY	0	1,362	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10 09910	CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00 10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	7,671	8,946	0	118.00
NONREIMBURSABLE COST CENTERS					
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)	380,828	26,259	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	49.645157	2.935278	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	24,017	715	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	3.130883	0.079924	0.000000	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet C
Part I
Date/Time Prepared:
12/21/2018 1:44 pm

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		12,174,458		12,211,684	30.00
43.00	04300 NURSERY		0		0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		6,152,495		6,175,233	50.00
51.00	05100 RECOVERY ROOM		0		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0		0	52.00
53.00	05300 ANESTHESIOLOGY		1,699,328		1,699,328	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		4,599,847		4,599,847	54.00
60.00	06000 LABORATORY		5,208,033		5,208,033	60.00
60.01	06001 BLOOD LABORATORY		0		0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD		132,518		132,518	62.00
65.00	06500 RESPIRATORY THERAPY	0	46,512		46,512	65.00
66.00	06600 PHYSICAL THERAPY	0	2,458,172		2,458,172	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	162,051		162,051	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	68.00
69.00	06900 ELECTROCARDIOLOGY		1,669,507		1,669,507	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		7,114,237		7,114,237	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		950,750		950,750	73.00
74.00	07400 RENAL DIALYSIS		0		0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0	89.00
90.00	09000 CLINIC		10,519,035		10,519,035	90.00
91.00	09100 EMERGENCY		15,173,511	186,435	15,359,946	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)		885,418		885,418	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10	09910 CORF		0		0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION		0		0	109.00
110.00	11000 INTESTINAL ACQUISITION		0		0	110.00
111.00	11100 ISLET ACQUISITION		0		0	111.00
200.00	Subtotal (see instructions)	0	68,945,872	246,399	69,192,271	200.00
201.00	Less Observation Beds		885,418		885,418	201.00
202.00	Total (see instructions)	0	68,060,454	246,399	68,306,853	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet C
Part I
Date/Time Prepared:
12/21/2018 1:44 pm

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				
9.00	10.00						
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,812,788		6,812,788		30.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	340,036	14,282,478	14,622,514	0.420755	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	48,892	6,782,779	6,831,671	0.248743	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	736,556	12,702,847	13,439,403	0.342266	54.00
60.00	06000	LABORATORY	885,036	9,062,159	9,947,195	0.523568	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	4,229	89,927	94,156	1.407430	62.00
65.00	06500	RESPIRATORY THERAPY	339,220	387,760	726,980	0.063980	65.00
66.00	06600	PHYSICAL THERAPY	19,137	1,352,085	1,371,222	1.792687	66.00
67.00	06700	OCCUPATIONAL THERAPY	777	218,972	219,749	0.737437	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	62,460	681,681	744,141	2.243536	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	8,235	1,122,162	1,130,397	6.293574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,441,920	2,207,494	3,649,414	0.260521	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	27,676,806	27,676,806	0.380067	90.00
91.00	09100	EMERGENCY	512,628	18,457,845	18,970,473	0.799849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	334,382	2,843,226	3,177,608	0.278643	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	11,546,296	97,868,221	109,414,517		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,546,296	97,868,221	109,414,517		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet C Part I Date/Time Prepared: 12/21/2018 1:44 pm
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.422310		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.248743		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.342266		54.00
60.00	06000 LABORATORY	0.523568		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	1.407430		62.00
65.00	06500 RESPIRATORY THERAPY	0.063980		65.00
66.00	06600 PHYSICAL THERAPY	1.792687		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.737437		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	2.243536		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	6.293574		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.260521		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.380067		90.00
91.00	09100 EMERGENCY	0.809676		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.278643		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet C
Part I
Date/Time Prepared:
12/21/2018 1:44 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		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	12,174,458		12,174,458	37,226	12,211,684	30.00
43.00	04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	6,152,495		6,152,495	22,738	6,175,233	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	1,699,328		1,699,328	0	1,699,328	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,599,847		4,599,847	0	4,599,847	54.00
60.00	06000 LABORATORY	5,208,033		5,208,033	0	5,208,033	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	132,518		132,518	0	132,518	62.00
65.00	06500 RESPIRATORY THERAPY	46,512	0	46,512	0	46,512	65.00
66.00	06600 PHYSICAL THERAPY	2,458,172	0	2,458,172	0	2,458,172	66.00
67.00	06700 OCCUPATIONAL THERAPY	162,051	0	162,051	0	162,051	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	1,669,507		1,669,507	0	1,669,507	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	7,114,237		7,114,237	0	7,114,237	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	950,750		950,750	0	950,750	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	10,519,035		10,519,035	0	10,519,035	90.00
91.00	09100 EMERGENCY	15,173,511		15,173,511	186,435	15,359,946	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	885,418		885,418	0	885,418	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
200.00	Subtotal (see instructions)	68,945,872	0	68,945,872	246,399	69,192,271	200.00
201.00	Less Observation Beds	885,418		885,418	0	885,418	201.00
202.00	Total (see instructions)	68,060,454	0	68,060,454	246,399	68,306,853	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet C
Part I
Date/Time Prepared:
12/21/2018 1:44 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,812,788		6,812,788		30.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	340,036	14,282,478	14,622,514	0.420755	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	48,892	6,782,779	6,831,671	0.248743	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	736,556	12,702,847	13,439,403	0.342266	54.00
60.00	06000	LABORATORY	885,036	9,062,159	9,947,195	0.523568	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	4,229	89,927	94,156	1.407430	62.00
65.00	06500	RESPIRATORY THERAPY	339,220	387,760	726,980	0.063980	65.00
66.00	06600	PHYSICAL THERAPY	19,137	1,352,085	1,371,222	1.792687	66.00
67.00	06700	OCCUPATIONAL THERAPY	777	218,972	219,749	0.737437	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	62,460	681,681	744,141	2.243536	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	8,235	1,122,162	1,130,397	6.293574	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,441,920	2,207,494	3,649,414	0.260521	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	27,676,806	27,676,806	0.380067	90.00
91.00	09100	EMERGENCY	512,628	18,457,845	18,970,473	0.799849	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	334,382	2,843,226	3,177,608	0.278643	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	11,546,296	97,868,221	109,414,517		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	11,546,296	97,868,221	109,414,517		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet C Part I Date/Time Prepared: 12/21/2018 1:44 pm
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
51.00	05100 RECOVERY ROOM	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0.000000		62.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
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: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet D Part I Date/Time Prepared: 12/21/2018 1:44 pm		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
Title XVIII Hospital PPS								
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,134,947	0	1,134,947	3,448	329.16	30.00	
43.00	NURSERY	0		0	0	0.00	43.00	
200.00	Total (lines 30 through 199)	1,134,947		1,134,947	3,448		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	515	169,517					30.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	515	169,517					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet D Part II Date/Time Prepared: 12/21/2018 1:44 pm
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	587,881	14,622,514	0.040204	38,158	1,534	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	115,641	6,831,671	0.016927	1,869	32	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	742,858	13,439,403	0.055275	94,738	5,237	54.00
60.00	06000 LABORATORY	376,536	9,947,195	0.037853	145,441	5,505	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	13,732	94,156	0.145843	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	32,415	726,980	0.044589	50,941	2,271	65.00
66.00	06600 PHYSICAL THERAPY	138,443	1,371,222	0.100963	7,457	753	66.00
67.00	06700 OCCUPATIONAL THERAPY	33,660	219,749	0.153175	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	105,784	744,141	0.142156	62,460	8,879	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	236,289	1,130,397	0.209032	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	25,419	3,649,414	0.006965	156,886	1,093	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	991,124	27,676,806	0.035811	0	0	90.00
91.00	09100 EMERGENCY	774,777	18,970,473	0.040841	78,987	3,226	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT)	82,290	3,177,608	0.025897	49,823	1,290	92.00
200.00	Total (lines 50 through 199)	4,256,849	102,601,729		686,760	29,820	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet D Part III Date/Time Prepared: 12/21/2018 1:44 pm			
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0		30.00	
43.00	04300	NURSERY	0	0	0	0	0		43.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0		200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 + col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	3,448	0.00	515		30.00	
43.00	04300	NURSERY	0	0	0	0.00	0		43.00	
200.00		Total (lines 30 through 199)	0	0	3,448	0.00	515		200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost						
			9.00	13.00						
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0						30.00
43.00	04300	NURSERY	0	0						43.00
200.00		Total (lines 30 through 199)	0	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet D Part IV Date/Time Prepared: 12/21/2018 1:44 pm
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Cost Center Description	Title XVIII					Hospital		PPS
	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health			
	1.00	2A	2.00	3A	3.00			
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	50.00	
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00	
60.00 06000 LABORATORY	0	0	0	0	0	0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	60.01	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	0	62.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	0	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00	
90.00 09000 CLINIC	0	0	0	0	0	0	90.00	
91.00 09100 EMERGENCY	0	0	0	0	0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT)	0	0	0	0	0	0	92.00	
200.00 Total (lines 50 through 199)	0	0	0	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet D Part IV Date/Time Prepared: 12/21/2018 1:44 pm
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Cost Center Description		Title XVIII			Hospital	PPS		
		All Other Medical Education Cost	Total Cost (sum of col. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	14,622,514	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,831,671	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	13,439,403	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,947,195	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0	0	0	94,156	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	726,980	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,371,222	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	219,749	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	744,141	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	1,130,397	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	3,649,414	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	27,676,806	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	18,970,473	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0	0	0	3,177,608	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	102,601,729		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet D
Part IV
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description		Title XVIII			Hospital		
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	38,158	0	2,011,019	0 50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,869	0	160,378	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	94,738	0	1,036,487	0 54.00
60.00	06000	LABORATORY	0.000000	145,441	0	625,507	0 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	0.000000	0	0	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	50,941	0	47,426	0 65.00
66.00	06600	PHYSICAL THERAPY	0.000000	7,457	0	869	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	62,460	0	314,369	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	0.000000	0	0	22,234	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	156,886	0	248,699	0 73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0 89.00
90.00	09000	CLINIC	0.000000	0	0	1,924,913	0 90.00
91.00	09100	EMERGENCY	0.000000	78,987	0	1,052,539	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT)	0.000000	49,823	0	234,274	0 92.00
200.00		Total (lines 50 through 199)		686,760	0	7,678,714	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet D Part IV Date/Time Prepared: 12/21/2018 1:44 pm
Title XVIII		Hospital	PPS

Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost	
		21.00	24.00	
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	92.00
200.00	Total (lines 50 through 199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet D
Part V
Date/Time Prepared:
12/21/2018 1:44 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		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.420755	2,011,019	0	0	846,146	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.248743	160,378	0	0	39,893	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.342266	1,036,487	0	0	354,754	54.00
60.00	06000	LABORATORY	0.523568	625,507	0	0	327,495	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD	1.407430	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.063980	47,426	0	0	3,034	65.00
66.00	06600	PHYSICAL THERAPY	1.792687	869	0	0	1,558	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.737437	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2.243536	314,369	0	0	705,298	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PAT	6.293574	22,234	0	0	139,931	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	0.260521	248,699	2,705	103,552	64,791	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.380067	1,924,913	0	80	731,596	90.00
91.00	09100	EMERGENCY	0.799849	1,052,539	0	0	841,872	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT	0.278643	234,274	0	0	65,279	92.00
200.00		Subtotal (see instructions)		7,678,714	2,705	103,632	4,121,647	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		7,678,714	2,705	103,632	4,121,647	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet D Part V Date/Time Prepared: 12/21/2018 1:44 pm
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	705	26,977		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	30		90.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0		92.00
200.00 Subtotal (see instructions)	705	27,007		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 - line 201)	705	27,007		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet D-1 Date/Time Prepared: 12/21/2018 1:44 pm
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,448	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,448	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,198	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)		515	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		12,211,684	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)		12,211,684	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		12,211,684	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		3,541.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,823,960	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)		1,823,960	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet D-1 Date/Time Prepared: 12/21/2018 1:44 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XVIII		1.00	2.00	3.00	4.00	5.00	
Hospital						PPS	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					400,621	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,224,581	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)					169,517	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					29,820	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					199,337	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,025,244	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)					250	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					3,541.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					885,418	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet D-1 Date/Time Prepared: 12/21/2018 1:44 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	1,134,947	12,211,684	0.092939	885,418	82,290	90.00
91.00	Nursing School cost	0	12,211,684	0.000000	885,418	0	91.00
92.00	Allied health cost	0	12,211,684	0.000000	885,418	0	92.00
93.00	All other Medical Education	0	12,211,684	0.000000	885,418	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet D-3 Date/Time Prepared: 12/21/2018 1:44 pm	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		919,435		30.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.422310	38,158	16,115	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.248743	1,869	465	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.342266	94,738	32,426	54.00
60.00	06000 LABORATORY	0.523568	145,441	76,148	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	1.407430	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.063980	50,941	3,259	65.00
66.00	06600 PHYSICAL THERAPY	1.792687	7,457	13,368	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.737437	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2.243536	62,460	140,131	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	6.293574	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	0.260521	156,886	40,872	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.380067	0	0	90.00
91.00	09100 EMERGENCY	0.809676	78,987	63,954	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0.278643	49,823	13,883	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		686,760	400,621	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)		686,760		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 12/21/2018 1:44 pm
		Title XVIII	Hospital	PPS
		1.00		
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		494,335	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		98,867	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)		69,891	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		175,106	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		24.32	4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		18.13	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)		18.13	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		2.40	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)		2.40	12.00
13.00	Total allowable FTE count for the prior year.		2.91	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.		3.45	14.00
15.00	Sum of lines 12 through 14 divided by 3.		2.92	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		2.92	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.120066	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.136300	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.120066	21.00
22.00	IME payment adjustment (see instructions)		37,633	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		11,109	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		-15.73	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)		37,633	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		11,109	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		11.79	30.00
31.00	Percentage of Medicaid patient days (see instructions)		44.75	31.00
32.00	Sum of lines 30 and 31		56.54	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		17,796	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 12/21/2018 1:44 pm
		Title XVIII	Hospital	PPS
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0 35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,775,083	4,426,596	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	1,478,426	739,786	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,218,212		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
		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)	2,936,734		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)		2,947,843	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		66,112	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).		22,889	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		3,036,844	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		3,036,844	61.00
62.00	Deductibles billed to program beneficiaries		119,025	62.00
63.00	Coinurance billed to program beneficiaries		0	63.00
64.00	Allowable bad debts (see instructions)		22,895	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		14,882	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,371	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		2,932,701	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		0	70.93
70.94	HRR adjustment amount (see instructions)		0	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part A Date/Time Prepared: 12/21/2018 1:44 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			2,932,701	71.00
71.01	Sequestration adjustment (see instructions)			58,654	71.01
71.02	Demonstration payment adjustment amount after sequestration			0	71.02
72.00	Interim payments			2,121,567	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)			752,480	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			207,800	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			21,009	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		1.0000000000	1.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.9983	0.9983	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 12/21/2018 1:44 pm	
		PPS					
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	11.79	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	44.75	0.00			44.75	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	56.54	0.00			44.75	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	24.32	0.00			24.32	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	12.00	0.00			26.13	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	606	0			606	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	265	0			265	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	560	0			560	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,431	0			1,431	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	3,198	0			3,198	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	3,198	0			3,198	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	44.75	0.00			44.75	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet DSH Date/Time Prepared: 12/21/2018 1:44 pm	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	35.86		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		35.86		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		35.86		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet DSH Date/Time Prepared: 12/21/2018 1:44 pm
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	26.13		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	26.13		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH with less than 100 beds the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	26.13		31.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
12/21/2018 1:44 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	494,335	0	494,335		494,335	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	98,867	0		98,867	98,867	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	69,891	0	58,242	11,648	69,890	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	175,106	0	145,922	29,184	175,106	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.120066	0.120066	0.120066	0.120066		5.00
6.00	IME payment adjustment (see instructions)	22.00	37,633	0	31,361	6,272	37,633	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	11,109	0	11,109	0	11,109	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	37,633	0	31,361	6,272	37,633	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	11,109	0	11,109	0	11,109	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	17,796	0	14,830	2,966	17,796	11.00
11.01	Uncompensated care payments	36.00	2,218,212	0	396,697	296,657	693,354	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,936,734	0	2,520,324	416,410	2,936,734	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	2,947,843	0	2,531,433	416,410	2,947,843	15.00
16.00	Payment for inpatient program capital (From Wkst. L, Pt. I, if applicable)	50.00	66,112	0	55,093	11,019	66,112	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet E
Part A Exhibit 4
Date/Time Prepared:
12/21/2018 1:44 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	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	2,586,526	427,429	3,013,955	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	48,311	0	40,259	8,052	48,311	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	13,033	0	10,861	2,172	13,033	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	0.0987	0.0987	0.0987	0.0987		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	4,768	0	3,973	795	4,768	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	66,112	0	55,093	11,019	66,112	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				0.250000	0.250000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			646,632		646,632	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				106,857	106,857	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: 14-0300		Period: From 12/01/2017 To 11/30/2018		Worksheet E Part A Exhibit 5 Date/Time Prepared: 12/21/2018 1:44 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	494,335	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	98,867		0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	69,891	0		0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0	2.01
3.00	Operating outlier reconciliation	2.01	0	0		0	3.00
4.00	Managed care simulated payments	3.00	175,106	0		0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.120066	0.120066	0.120066		5.00
6.00	IME payment adjustment (see instructions)	22.00	37,633	37,633	0	37,633	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	11,109	11,109	0	11,109	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	37,633	37,633	0	37,633	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	11,109	11,109	0	11,109	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	17,796	17,796	0	17,796	11.00
11.01	Uncompensated care payments	36.00	2,218,212	1,478,426	739,786	2,218,212	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,936,734	2,196,948	739,786	2,936,734	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	2,947,843	2,208,057	739,786	2,947,843	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	66,112	55,093	11,019	66,112	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			2,263,150	750,805	3,013,955	19.00

		Title XVIII			Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	48,311	40,259	8,052	48,311	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	13,033	10,861	2,172	13,033	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	0.0987	0.0987	0.0987		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	4,768	3,973	795	4,768	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	66,112	55,093	11,019	66,112	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	0	0	0	0	30.00	
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01	
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part B Date/Time Prepared: 12/21/2018 1:44 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		27,712	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,121,647	2.00
3.00	OPPS payments		2,845,857	3.00
4.00	Outlier payment (see instructions)		246,033	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)		27,712	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		106,337	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)		106,337	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		106,337	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		78,625	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)		27,712	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)		3,091,890	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		712,237	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,407,365	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		42,692	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,450,057	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		2,450,057	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		291,195	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		189,277	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,138	36.00
37.00	Subtotal (see instructions)		2,639,334	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,639,334	40.00
40.01	Sequestration adjustment (see instructions)		52,787	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		2,464,825	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		121,722	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		118,819	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: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E Part B Date/Time Prepared: 12/21/2018 1:44 pm
Title XVIII		Hospital	PPS
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)			0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet E-1
Part I
Date/Time Prepared:
12/21/2018 1:44 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		2,121,567		2,464,825	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,121,567		2,464,825	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		752,480		121,722	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,874,047		2,586,547	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101			8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E-1 Part II Date/Time Prepared: 12/21/2018 1:44 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
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			108.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E-4 Date/Time Prepared: 12/21/2018 1:44 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			11.59	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			11.59	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2.40	6.00
7.00	Enter the lesser of line 5 or line 6			2.40	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.34	2.34	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	2.34	2.34	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	2.34		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.36	2.52		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.98	2.35		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.45	2.40		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.45	2.40		17.00
18.00	Per resident amount	125,371.16	111,866.46		18.00
19.00	Approved amount for resident costs	56,417	268,480	324,897	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			324,897	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions)	515	152		26.00
27.00	Total Inpatient Days (see instructions)	3,198	3,198		27.00
28.00	Ratio of inpatient days to total inpatient days	0.161038	0.047530		28.00
29.00	Program direct GME amount	52,321	15,442		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		2,182		30.00
31.00	Net Program direct GME amount			65,581	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet E-4 Date/Time Prepared: 12/21/2018 1:44 pm
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		2,224,581	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		2,224,581	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		4,149,359	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		4,149,359	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		6,373,940	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.349012	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.650988	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		65,581	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		22,889	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		42,692	50.00

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

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet G

Date/Time Prepared:
12/21/2018 1:44 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	318,025,388	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	97,664,189	0	0	0	4.00
5.00	Other receivable	-106,797,490	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-129,331	0	0	0	6.00
7.00	Inventory	1,803,879	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	310,566,635	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	52,527,944	0	0	0	15.00
16.00	Accumulated depreciation	-35,259,748	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	505,260	0	0	0	19.00
20.00	Accumulated depreciation	-477,361	0	0	0	20.00
21.00	Automobiles and trucks	78,692	0	0	0	21.00
22.00	Accumulated depreciation	-78,692	0	0	0	22.00
23.00	Major movable equipment	13,421,929	0	0	0	23.00
24.00	Accumulated depreciation	-12,078,724	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)	18,639,300	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	329,205,935	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	17,379,152	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,378,370	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	515,016	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,272,538	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	20,272,538	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	308,933,397				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)	308,933,397	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	329,205,935	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet G-1

Date/Time Prepared:
12/21/2018 1:44 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		244,717,663		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		83,976,871			2.00
3.00	Total (sum of line 1 and line 2)		328,694,534		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		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)		328,694,534		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00	Rounding	19,761,137		0		17.00
18.00	Total deductions (sum of lines 12-17)		19,761,137		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		308,933,397		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			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00	Rounding		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: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet G-2
Parts I & II
Date/Time Prepared:
12/21/2018 1:44 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	7,645,716		7,645,716	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	7,645,716		7,645,716	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	7,645,716		7,645,716	17.00
18.00	Ancillary services	2,292,935	37,977,591	40,270,526	18.00
19.00	Outpatient services	474,728	38,923,842	39,398,570	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other Patient Service Revenue	2,435,628	-290,599	2,145,029	27.00
27.02	Capitation Revenue - Net	114,825,522	0	114,825,522	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	127,674,529	76,610,834	204,285,363	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51,858,507		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		51,858,507		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0300

Period:
From 12/01/2017
To 11/30/2018

Worksheet G-3

Date/Time Prepared:
12/21/2018 1:44 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	204,285,363	1.00
2.00	Less contractual allowances and discounts on patients' accounts	69,183,046	2.00
3.00	Net patient revenues (line 1 minus line 2)	135,102,317	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	51,858,507	4.00
5.00	Net income from service to patients (line 3 minus line 4)	83,243,810	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	3,320	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	113,951	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	240,665	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	392,218	23.00
24.00	Misc. Income	-17,093	24.00
25.00	Total other income (sum of lines 6-24)	733,061	25.00
26.00	Total (line 5 plus line 25)	83,976,871	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	83,976,871	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0300	Period: From 12/01/2017 To 11/30/2018	Worksheet L Parts I-III Date/Time Prepared: 12/21/2018 1:44 pm
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		48,311	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		13,033	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)		8.76	3.00
4.00	Number of interns & residents (see instructions)		2.92	4.00
5.00	Indirect medical education percentage (see instructions)		9.87	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)		4,768	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		66,112	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00